Resident Physician

NOVEMBER
1960
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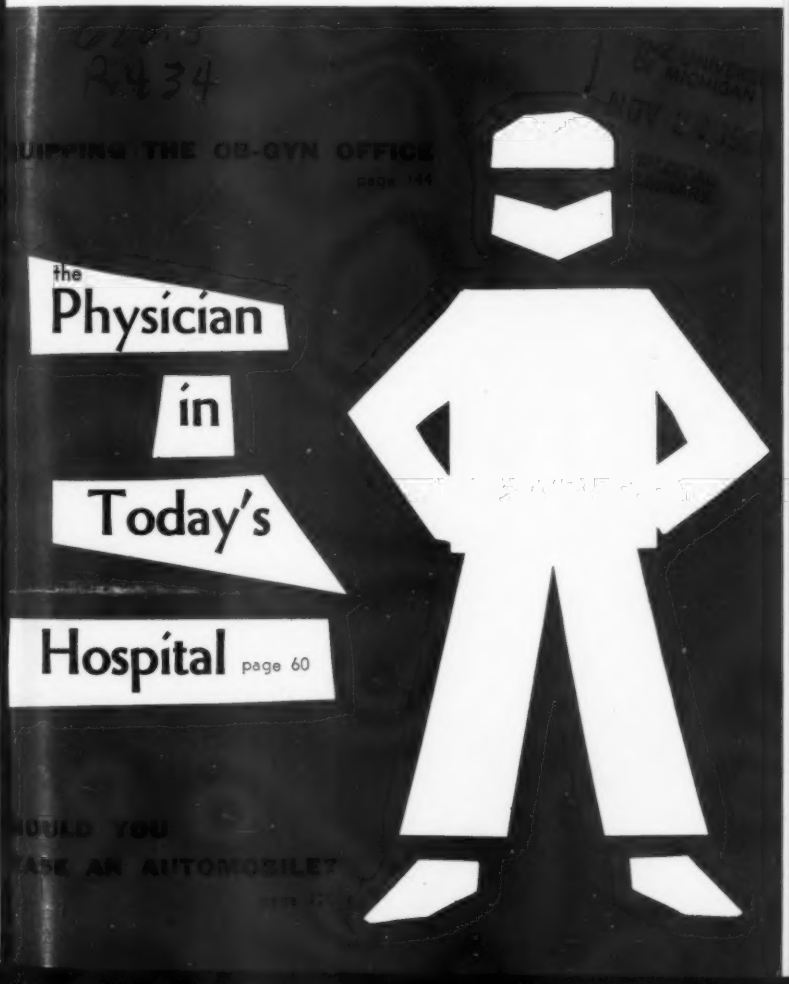
JOURNAL FOR THE HOSPITAL STAFF OFFICER



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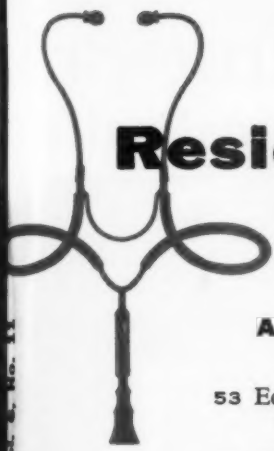


Resident Physician

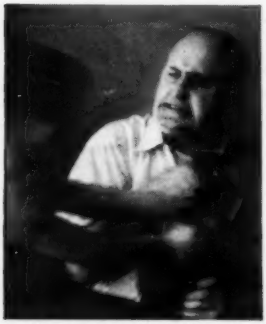
Articles

The Resident Physician is published monthly on the fifteenth by The Resident, Inc., with publication offices at 34 North Crystal Street, East Stroudsburg, Pennsylvania. Executive, advertising and editorial offices at 1447 Northern Boulevard, Manhasset, New York. If undelivered, please send form 3547 to Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

announcing "Timovan"®

Brand of Prothipendyl hydrochloride

completely new calmative



for the temperamental older patient

for the emotional teen-ager

Specifically developed for active patients in need of calming without the "slow-down" of sedatives or the hazards of many tranquilizers. "TIMOVAN" offers a new range of safety and effectiveness in the relief of tension in the ambulatory patient, notably the adolescent and the geriatric. Particularly valuable in conditions in which excessive emotional response complicates therapy, as in dermatoses and allergies.[1-4]

- Reduces excessive response to irritating stimuli.
- Stabilizes the autonomic nervous system.
- Nonhypnotic, yet improves sleep pattern.
- No sensitivity reactions or toxicity reported.
- Has not given rise to drug tolerance even on prolonged use.
- Nonaddictive.
- Preferred to barbiturates.

DOSAGE: One or two tablets three or four times daily. Depending on age of patient and severity of symptoms, dosages ranging from 100 mg. to 400 mg. daily (in divided doses) have been used effectively and safely.

CONTRAINDICATIONS: Not to be used in cases of acute alcoholism or barbiturate poisoning.

SUPPLIED: "TIMOVAN" No. 739 — 25 mg. tablets. No. 740 — 50 mg. tablets. Bottles of 100 and 1,000.

REFERENCES: 1. Medical Records of Chemiewerk Homburg A/G. 2. Linke, H.: München. med. Wchnschr. 100:969 (June 20) 1958. 3. Quandt, V. J., Von Horn, L., and Schliep, H.: Psychiat. et Neurol. 135:197 (Mar.) 1958. 4. Medical Records of Ayerst Laboratories.

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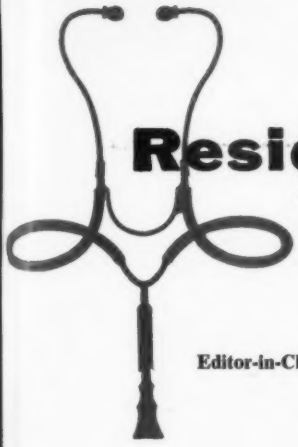
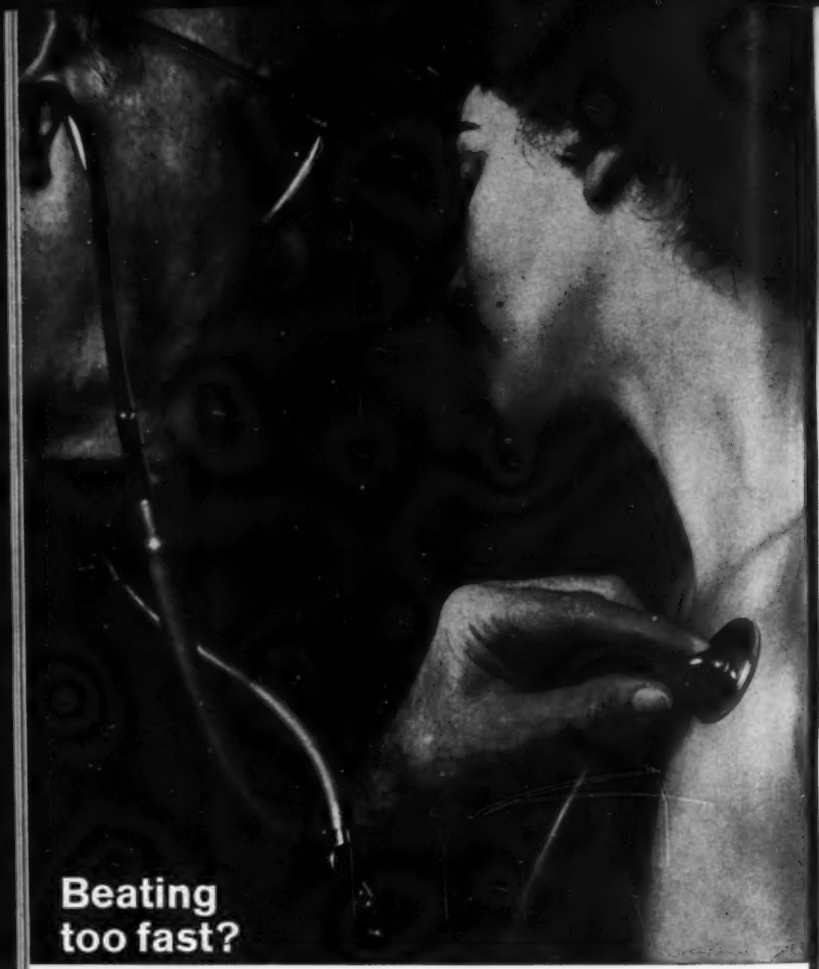


Resident Physician

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians and interns. When possible, two copies of the manuscript should be submitted.

West Coast Representative: Ren Averill, Ren Averill Company, 232 North Lake Avenue, Pasadena, California. Southwestern Representative: John L. Hathaway, Ren Averill Company, 2603 Nicholson Drive, Dallas 24, Texas. Subscription rate $10.00 per year. Single copies $1.00. Notify publisher promptly of change of address.



Slow it down with SERPASIL®

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Serpasil has proved effective as a heart-slowing agent in the following conditions: mitral disease; myocardial infarction; cardiac arrhythmias; neurocirculatory asthenia; thyroid toxicosis; excitement and effort syndromes; cardiac neurosis; congestive failure. Serpasil should be used with caution in patients receiving digitalis and quinidine. It is not indicated in cases of aortic insufficiency.

SUPPLIED: Tablets, 0.1 mg., 0.25 mg. (scored) and 1 mg. (scored).
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sprained wrist

Analgesics alone merely mask pain. New Medaprin adds Medrol* to suppress the inflammation that *caus* the pain and stiffness. Thus, to the direct relief o musculoskeletal pain,

Medaprin

adds restoration of function.

Medaprin is supplied in bottles o 100 and 500 tablets.

Each tablet contains:
Medrol (methylprednisolone) .. 1
Acetylsalicylic Acid 300
(5 g
Calcium Carbonate 200

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Resident Physician

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BREMIL®

LIQUID / POWDERED

matches mother's milk

in total infant nutrition with a physiologically balanced, complete formula—for a clinically smoother course of formula feeding

easier on everyone concerned—because BREMIL-fed babies are less subject to commonly occurring problems such as digestive upset, diaper rash, perianal dermatitis, and hyperirritability (only *liquid* formula food with a guaranteed standardized physiologic Ca:P ratio of 1½:1)

efficient, well utilized protein, patterned on mother's milk, encourages excellent growth but helps avoid excessive renal solute load, thus guarding against stress-induced dehydration

Standard Dilution:

Liquid—1:1 with water.
13-fl.oz. tins.

Powdered—1 level measure to 2 fl.oz. hot water.
1-lb. tins.

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Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk (*).

TO FIT YOUR PATIENT...

NEW...

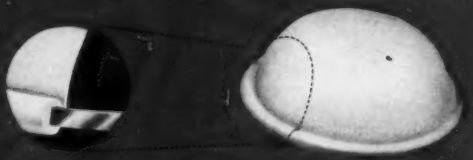
ORTHO® Arcing Spring Diaphragm

Forms a perfect arc—easy to insert...ideal for the normal and difficult-to-fit patient.

ORTHO® Diaphragm (Coil Spring)

Flexes in all planes—adapts readily to irregular contours of the vagina... assures optimal fit and comfort.

ORTHO®-WHITE Diaphragm (Flat Spring)



Flexes in one plane—inserts easily, needs no introducer... light as a feather and white as snow.

A COMPLETE CHOICE

Ortho

The Aged

–and a natural way to meet their special nutrition needs with fresh-flavor, economical Carnation Instant.

Finicky appetites, dental problems, food costs—one or more often play a part in contributing to poor diet for the elderly.

A pleasant *natural* way to help improve their nutritional status is the excellent new food—*new Carnation Instant Nonfat Dry Milk mixed 25% over-strength.*

One-third cup extra crystals per liquid quart when mixing provides 25% more calcium, protein, and B-vitamins than ordinary nonfat milk. Because your patients can add this additional amount, they get *needed* nutrients—*without* excessive calories. And the richer, more delicious flavor of nonfat milk mixed over-strength is a *natural* way to *extra* nutrition they'll enjoy. Costs them only 12¢ a quart.

ANOTHER QUALITY PRODUCT OF CARNATION COMPANY, LOS ANGELES 36, CALIFORNIA

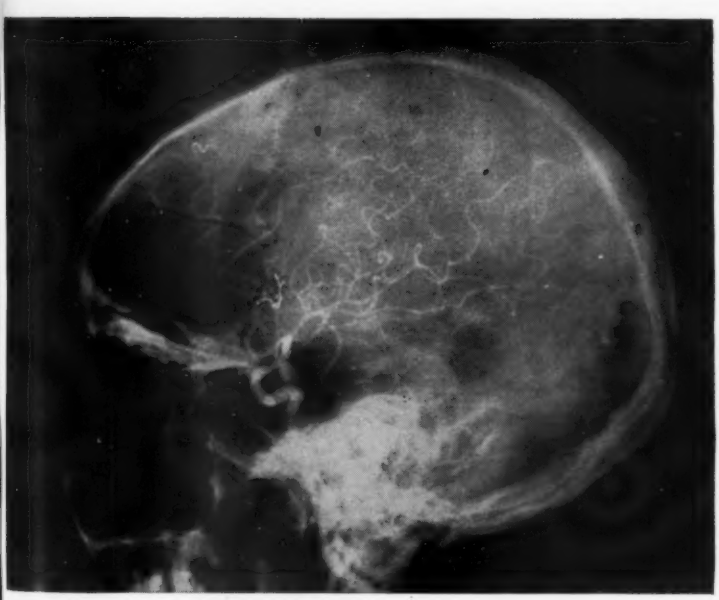
Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

WHICH IS YOUR DIAGNOSIS?

1. Normal 2. Aneurysm 3. Tumor

(Answer on page 168)



Now—with

Alvodine

ethanesulfonate trademark Brand of piminodine ethanesulfonate

relief of severe pain without drowsiness or hypnosis*

new approach to "pure" analgesia

Alvodine, a new potent narcotic analgesic which approaches "pure" analgesia, is unique among agents of its class because it is as effective as morphine but does not produce drowsiness, hypnosis or euphoria in the great majority of patients.

Alvodine is safer than morphine. It is free of both the high incidence and the severity of side effects associated with morphine. Respiratory and circulatory depression are rare with customary dosages. Nausea and vomiting are uncommon and, unlike opiates, Alvodine does not cause constipation.

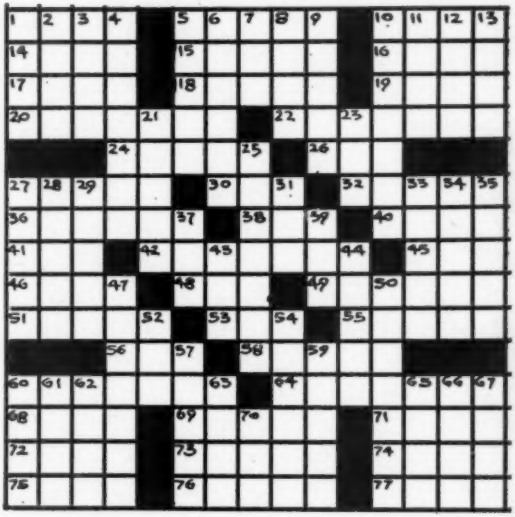
In contrast to most other analgesics Alvodine is fully effective when administered orally. Injection may be given for quick action or when parenteral use is indicated.

Alvodine tablets*, 50 mg., scored. Average oral dose for adults—from 25 to 50 mg. every four to six hours as required. *Alvodine ampuls*, 1 cc., containing 20 mg. per cc. Average subcutaneous or intramuscular dose for adults—from 10 to 20 mg. every four hours as required. *Narcotic Blank Required.

***In more than 90% of patients.**

Resident Relaxer

(Solution on page 168)



ACROSS

1. Back of the leg
5. A work basket
10. Front of the head
14. Pertaining to the mouth
15. To miscarry
16. Was indebted to
17. Mycobacterium (abbr.)
18. South American animal
19. Any abnormal respiratory sound
20. Inability to forget
22. Used for spraying
24. A number
26. The popliteal region
27. Part of a flower
30. Organ of hearing
32. Herb (Span.)
36. Usual condition
38. A sebaceous cyst
40. Horny dorsal plate on a finger or toe
41. Suffix designating an enzyme
42. Habitual petty criminal
45. 540 (Rom.)
46. Ascend
48. General paralysis of the insane (abbr.)
49. Alertness of mind and will
51. Follow
53. Tin, carbon (symbols)
55. Pretty
56. Grains (abbr.)
58. One in charge of horses
60. A disease which is local, not sporadic
64. Mind blindness
68. Neon, anode (symbols)
69. Depart
71. Power (comb. form)
72. The ankle bone (pl.)
73. Any part of the body having a special function
74. The haunch bone (pl.)
75. Pertaining to the ear
76. A saline purgative
77. Collapsible beds

DOWN

1. Loss of consciousness
2. A chemical prefix
3. Openwork fabric
4. Wreckage of a ship
5. Cup-shaped organ or cavity
6. Remove, especially by cutting
7. Large snake
8. Upper extremities
9. Bacteria found in boils
10. A hole in a bone
11. Absent
12. Suffix signifying a swelling
13. River in Germany Pertaining to a depression in an organ
23. A line of light
25. Deep involuntary respiration
27. Wire loop used for removing polyps
28. A red coal tar dye
29. Squeeze
31. A color
33. A radioactive element
34. An orange-red stain
35. To relieve
37. Piece of timber
39. Born
43. Increases (slang)
44. Redness due to inflammation
47. Pertaining to improvement of offspring
50. Wandering
52. Ermine (abbr.)
54. A form of bandage
57. Storage bins for grain
59. Uncovers
60. Within (prefix)
61. Tidy
62. Surrealist painter
63. Wax
65. Derivation from (comb. form)
66. Initial (abbr.)
67. An association of scientists
70. Silver, liter (symbols)

each part plays a key role

in cough control, too—
each component contributes to the efficacy of

BENYLIN® EXPECTORANT

potent antihistaminic—relieves nasal stuffiness, sneezing, lacrimation, itching, and bronchial congestion

proved expectorants—liquefy and loosen tenacious mucus...help clear the respiratory tree

time-tested antispasmodic—decreases bronchospasm; helps quiet the cough reflex

palatable demulcent—raspberry-flavored syrup soothes raw, irritated throat membranes...pleasant taste is readily acceptable to patients of all ages

BENYLIN EXPECTORANT contains in each fluidounce:

Benadryl® hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	80 mg.
Ammonium chloride	12 gr.
Sodium citrate	5 gr.
Chloroform	½ gr.
Menthol	0.1 gr.

supplied: BENYLIN EXPECTORANT is available in 16-ounce and 1-gallon bottles.

PARKE-DAVIS

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

Letters to the Editor

Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.

Small Car

This letter is in connection with the article on low-priced foreign cars which appeared in the June issue of RESIDENT PHYSICIAN. The comments which follow are in no way a rebuttal of the article but are simply my own impressions and observations. Your letters column provides me with a forum in which to air thoughts I have been mulling over for some time. And while I've been mulling, the popularity of small foreign cars has zoomed.

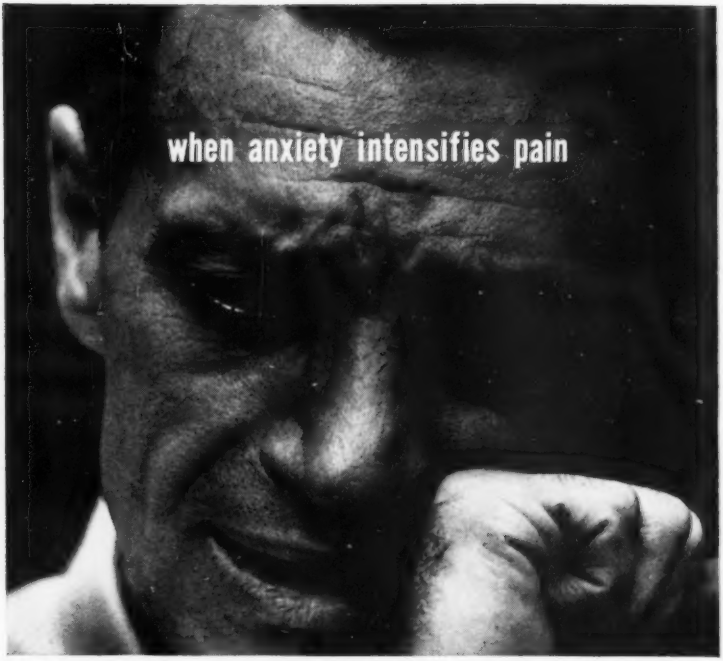
I am not a resident, having been in practice for some years. When I first opened my office, foreign cars were a rarity on the road and when I bought one I was far ahead of my time.

The machine was sturdy, well built, economical to run and—what appealed even more—relatively cheap to buy. I bought it in late summer and for the first few months was delighted with my small, nimble vehicle. Friends' jibes only served as amusement, and I would smile in a superior manner when they warned me to watch out for blobs of chewing gum on the road.

Then winter came—and with it disillusionment. I found the heater and defroster could produce only a thin stream of lukewarm air. Not only did I freeze but the windshield invariably turned into frosted glass in any kind of moderately heavy snowstorm. Several times I was forced to abandon ship because I could not see through the glaze in front of me.

I imagine that today the foreign-car makers are aware of this and have done something about it. But I wonder how much can

—Continued on page 40



. . . DARVO-TRAN® relieves pain more effectively than the analgesic components alone

Lilly

Effective analgesia *plus* safe relief of mild anxiety helps combat the pain-anxiety spiral. The unique Darvo-Tran formula adds the tranquilizing effects of Ultran® to the established analgesic advantages of Darvon® and A.S.A.®. Clinical and pharmacologic studies have shown that when pain is accompanied by anxiety, the addition of Ultran *enhances* and *prolongs* the analgesic effects of Darvon.

DARVO-TRAN DOES NOT REQUIRE
A NARCOTIC PRESCRIPTION.

Each Pulvule® Darvo-Tran provides:

Darvon	32 mg.	TO RAISE PAIN THRESHOLD
A.S.A.	325 mg.	
Ultran	150 mg.	TO RELIEVE ANXIETY

Usual Dosage:
1 or 2 Pulvules three or four times daily.

Darvo-Tran® (dextro propoxyphene and acetylsalicylic acid with phenaglycodol, Lilly)
Ultran® (phenaglycodol, Lilly)
Darvon® (dextro propoxyphene hydrochloride, Lilly)
A.S.A.® (acetylsalicylic acid, Lilly)

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I know I can
count on it
a reservoir of dependable performance
Terramycin® therapy
BRAND OF OXYTETRACYCLINE

IN BRIEF

The dependability of Terramycin is based on broad antimicrobial effectiveness, excellent toleration, and low order of toxicity. Terramycin Intramuscular Solution, a *preconstituted* parenteral form of oxytetracycline with 2% Xylocaine* as a local anesthetic, facilitates prompt initiation of broad-spectrum antibiotic therapy when, in the judgment of the physician, immediate oral administration is inconvenient or impractical. There is a notably low incidence of irritation or pain at the injection site. In an experimental study,† injection of Terramycin Intramuscular Solution produced the smallest amount of local tissue reaction as compared to other intramuscular broad-spectrum antibiotic preparations.

Now—the availability of a *new multi-dose* 10 cc. vial permits *dosage flexibility* and *economy* hitherto possible only with narrow-spectrum antibiotics. This is an advantage of particular value in pediatrics, where variations in age, weight, and severity of illness require individual dosage adjustment.

INDICATIONS: All oxytetracycline indications whenever initial or continuing therapy with I.M. injection is indicated. Compatible oral therapy may then be given with Cosa-Terramycin® Capsules, Cosa-Terrabon® Oral Suspension or Pediatric Drops. Effective against both gram-positive and gram-negative bacteria, rickettsiae, spirochetes, and large viruses, Terramycin therapy is indicated in a great variety of infections due to susceptible organisms, e.g., infections of the respiratory, gastrointestinal, and genitourinary tracts, surgical and soft-tissue infections, ophthalmic and otic infections, and many others.

ADMINISTRATION AND DOSAGE: For intramuscular injection only. Adults: Unless otherwise specified, a dose of 100 mg. every 8-12 hours, or a single daily dose of 250 mg. should be adequate for most mild or moderately severe infections. In *severe* infections, 100 mg. every 6-8 hours or 250 mg. every 12 hours may be necessary. Infants and children should receive proportionately less in accordance with age and weight of patient, and severity of infection.

SIDE EFFECTS AND PRECAUTIONS: Aside from occasional mild pain at injection site, adverse reactions (including allergic) have been rare. As with all I.M. preparations, injection should be made within the body of a relatively large muscle. After insertion of needle, aspiration should be attempted before injecting to avoid inadvertent administration into a blood vessel; care should always be taken to avoid injecting into a major nerve or its surrounding sheath. Subcutaneous and fat-layer injection may cause mild pain and induration, which may be relieved by an ice pack.

Use of antibiotics may result in an overgrowth of nonsusceptible organisms—particularly monilia and resistant staphylococci. If a new infection caused by a resistant pathogen appears, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing.

SUPPLIED: *Terramycin Intramuscular Solution* is available in a new 10 cc. multidose vial, providing five 2 cc. doses, 50 mg./cc., also available as 2 cc. prescored glass ampules, containing 100 mg. or 250 mg., packages of 5 and 100. For rapidly fulminating or critical infections—*Terramycin Intravenous*, in vials of 250 mg. and 500 mg. (buffered with 1 Gm. and 2 Gm. ascorbic acid, respectively). Available for oral therapy: *Cosa-Terramycin® Capsules*, 250 mg. and 125 mg.; *Cosa-Terrabon® Oral Suspension* (preconstituted), 125 mg. per 5 cc. teaspoonful, in bottles of 2 oz. and 1 pint; *Cosa-Terrabon® Pediatric Drops* (preconstituted), 5 mg. per drop (100 mg. per cc.), bottle of 10 cc. with calibrated plastic dropper. In addition, a variety of other systemic and local dosage forms are available to meet specific therapeutic requirements.

More detailed professional information available on request.

*XYLOCAINE® IS THE TRADEMARK OF ASTRA PHARMACEUTICAL PRODUCTS, INC. FOR ITS BRAND OF LIDOCAINE.

†*Hanson, D.: Tissue Reaction from Injected Antibiotics, Scientific Exhibit, Annual Meet., Am. Soc. Clin. Pathologists, Chicago, Sept., 1960.*

The Birth of Renal Surgery

Germany's most famous fistula specialist, Dr. Gustav Simon, had encountered many difficult problems, but Margaretha Kleb presented the worst fistula case in his experience. A year and a half earlier she had undergone surgery for removal of a huge ovarian tumor. Her inexperienced surgeon had removed a large portion of the left ureter thus destroying the channel between kidney and bladder, and the abdominal incision had remained open to form a fistula passage. Simon's attempts to correct the kidney drainage or suppress its function were futile. Then, postulating a revolutionary theory, he experimented with kidney removal in dogs and found it feasible. Next he perfected his operative technique on human cadavers, and the operation date on Margaretha Kleb was set for August 2, 1869.

Simon invited all his prominent colleagues to witness the surgery. He described his intentions and preparatory work – then began. Within ten minutes the kidney was exposed. Simon peeled it loose and drew it up while one of his assistants tied the hilum. Three ligatures were required to check the bleeding when the renal artery was severed. For the next 35 days the patient ran a stormy postoperative course. Then she improved, and recovery followed with astonishing speed. Six months after the operation, with the hilum healed and the incision closed, Simon discharged her as wholly cured—proving that one sound kidney could do the excretory work of two.

–JURGEN THORWALD: *The Century of the Surgeon*, New York, Pantheon Books Inc., 1957, pp. 180-198.

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Surgeon,
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No. 2 in a descriptive series on Abbott specialties

To save a life in cerebral edema

Ureaphil is an intravenous form of urea, recently introduced by Abbott for use wherever prompt diuresis is important. Response to Ureaphil can prove dramatic, even life-saving, in cerebral edema or oliguria following burns, surgery, and trauma.

Ureaphil provides the doctor a classically simple way to eliminate excess water. It disperses rapidly in the body fluids, and quickly finds its way to the renal tubules. Here it promptly cuts reabsorption of water by raising osmotic pressure.

This mechanism is normal and physiologic. It often produces diuresis even where potent mercurials become ineffective.

Ironically, though urea's diuretic efficacy has been known in oral form for a century, almost nobody used it. It tasted terrible, was hard to get down and keep down.

This problem is eliminated in intravenous Ureaphil, and the product is proving invaluable for difficult cases.

Ureaphil is indicated in cerebral edema before or during surgery, and sometimes where surgical intervention is not needed; and to counteract oliguria following burns, surgery, and trauma. It is useful after prostatectomy, when an abundant flow of urine may eliminate need for bladder irrigation. It is helpful, too, in edema due to heart failure, especially where mercurials cease to produce the desired effect.

Would you like more complete information? Write Professional Services, Abbott Laboratories, North Chicago, Ill.

UREAPHIL®

(Urea for Injection, Abbott)

ABBOTT

—*Continued from page 33*
be done with the smallest of the imports, especially the cars which do not have a water cooling system.

Another situation, which undoubtedly is improved today, is the matter of servicing. Parts were hard to get and special size tools were required, both of which made it impossible for me to use the services of my local garage. And most service stations could not give me a grease job—their lifts were too wide for my small machine.

So I had the inconvenience (and time loss) of a relatively long drive to the dealer for all servicing. As a result, I kept my fingers firmly crossed on the two out-of-state vacation trips I made with the car.

Another shortcoming not immediately evident was the constant shifting required in heavy traffic. With four forward speeds to contend with, my hand was constantly on the gear shift in any kind of highway jam. I don't imagine any of the economy imports come equipped with automatic drive, another important factor to consider.

Long trips proved very tiring because constant "driving" was required—no slouching back with one hand lightly on the wheel. And bumpy roads nearly sent me through the roof every time. I remain firmly convinced that no matter how superbly the small car is sprung it cannot—because of its short wheelbase—properly cope with bumpy roads. The action, as I recall, made me think I was on a bucking bronco.

The above were the main drawbacks, and they were serious enough to make me shy away (permanently, I think) from the small car. They far outweighed the economy of operation, ease of handling and other positive attributes. Perhaps the larger small car, the one more comparable to our standard sedan, is the answer. I don't know.

G. C. R., M.D.

New York, N. Y.

• *We will be happy to afford equal time to the small car proponents.*—Ed.

Contest Comment

My congratulations to you on spearheading the Mediquiz Program in your magazine to encourage increased reading among our House Officers. I will certainly do what I can to publicize this contest and will be glad to try and find out from our Rhode Island Hospital Librarian whether

—*Continued on page 44*

specify Bufferin® and avoid salicylate intolerance

Gastric distress due to aspirin used alone has been frequently reported.[1-7]

BUFFERIN is superior to plain aspirin in that it does not cause gastric intolerance; it is "... the drug of choice where prolonged, high salicylate levels are indicated." [8]

". . . is 4 to 5 times better tolerated than ordinary aspirin." [8]

And BUFFERIN acts fast, its absorption being expedited by the antacid components. [9]

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six sizes
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The wide range of sizes of 'VASELINE' STERILE PETROLATUM GAUZE U.S.P. gives it a thousand and one uses in the hospital and the office treatment room. As a pressure dressing in surgery . . . an occlusive dressing in burns . . . an emollient dressing on dry and nonacute skin lesions . . . a packing in nose, eye, and ear procedures . . . here is a dressing convenient to use and of guaranteed, sealed-in sterility.

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in disposable plastic tubes • 1/2" x 72" selvage-edged packing
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'Vaseline' Sterile Petrolatum Gauze U.S.P.

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a pair of cardiac patients:

both are free of pain—but only one is on

DILAUDID®

(Dihydromorphinone HCl)

swift, sure analgesia normally unmarred by nausea and vomiting

DILAUDID provides unexcelled analgesia in acute cardiovascular conditions. Onset of relief from pain is almost immediate. The high therapeutic ratio of DILAUDID is commonly reflected by lack of nausea and vomiting—and marked freedom from other side-effects such as dizziness and somnolence.

by mouth **by needle** **by rectum**

2 mg., 3 mg., and 4 mg.

May be habit forming—usual precautions should be observed as with other opiate analgesics.

KNOLL PHARMACEUTICAL COMPANY · ORANGE, NEW JERSEY

—*Continued from page 40*

she notices any obvious increase in library attendance with this contest.

Best of luck to you and hopes for a successful competition.

MARSHALL N. FULTON, M.D.
PROVIDENCE, R. I.

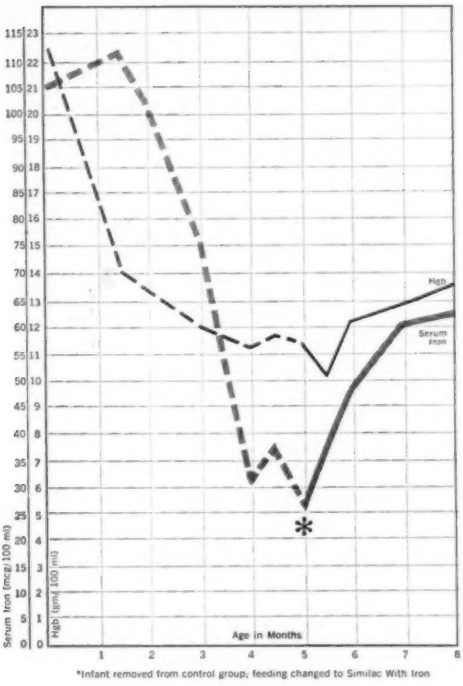
I too have been very interested in the reading habits of our Interns and Residents over the past years. I think that the physicians responsible for the training of the House Staff are largely responsible for indoctrinating these young men with the proper reading habits, and I have found that the enthusiasm of our House Staff varies directly with that of their teachers. We will be very happy to check with our librarian to see what the results of this contest sponsored by RESIDENT PHYSICIAN does in the way of stimulating the reading of the House Staff.

A. H. MEYER, M.D.

ASSISTANT HOSPITAL
ADMINISTRATOR-MEDICAL
HIGHLAND-ALAMEDA
COUNTY HOSPITAL
OAKLAND, CALIFORNIA

—*Concluded on page 48*

The hematologic progress of Infant #1810[1]



*Infant removed from control group; feeding changed to Similac With Iron

Male, healthy, one of a control group fed on evaporated milk formula

Decreased serum iron and elevated iron-binding capacity may precede by several weeks the fall in hemoglobin due to iron deficiency.[2] Prophylactic feedings of Similac With Iron (as with infant #1810[1]) can help prevent the development of clinical iron depletion.

Lahey points out, "Even a 'good' diet may, in the quantities eaten by an infant, provide less than the required amount of iron... evidence, then, suggests that though the physician should continue to recommend a 'good' diet, he should not depend solely on it for the prevention and cure of iron deficiency anemia in children."[2]

from a marginal deficiency to a comfortable margin with

Similac With Iron®

12 mg of ferrous iron per quart of formula

Assured Iron Intake in every Feeding to { **maintain iron reserves** / **protect against iron deficiency states** / **support the usual diet**

ROSS LABORATORIES
Columbus 16, Ohio

1. Marsh, A. K.: Personal communication.
2. Lahey, M. E.: Pediat. Clin. North America 4:481 (May) 1957.

Lifts depression...

You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers.

While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days.

Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage.

Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

▲Deprol▲®

CB-9199

WALLACE LABORATORIES / *Cranbury, N. J.*

—*Concluded from page 44*

. . . Re the contest, I firmly agree "It Pays To Read." I should like very much to receive RESIDENT PHYSICIAN personally.

EDWARD W. ABRAMS, M.D.
DIRECTOR, MEDICAL EDUCATION
SACRED HEART HOSPITAL
SPOKANE, WASHINGTON

Worthwhile Statement

It was indeed a great relief to read something nice and a few kind words about the foreign doctors. I refer to your Guest Editorial by Dr. Edward B. Williams, Jr., in the August issue of RESIDENT PHYSICIAN.

To my knowledge this is the first instance where an American has made a worthwhile statement about "us people." Prior to this, everybody including *Look* magazine had been writing things that might properly be lumped together under the heading of "trash." Everyone had been picking on foreigners and downgrading them so much that the word "foreign doctor" became synonymous with "criminal."

Look, in its article in March 29, 1960 issue, did its level best to prove the preceding statement. It let loose a lot of stray, uncorroborated and damaging ideas of an apparently very ignorant writer, onto the American lay public which as far as I know, is no different from any other public anywhere else in the world. This particular article of *Look* appeared so nasty that I, in conjunction with an American resident friend, was forced to write a plain reply to the magazine, for the benefit of the public. This letter of ours, of course, never saw print and *Look* was "sorry to have received it."

While it is very true that the American medical authorities are doing their best to clear up the confusion about the relative merits and demerits of the foreign graduate (the creation of the ECFMG for instance), it is the *Look* kind of propaganda that hurts the most. It is high time some concrete steps were taken to put an end to this sorry type of criticism.

I sincerely congratulate Dr. Williams for pioneering this movement and piloting of our apparently hopeless case. I also hope and pray that Dr. Williams will soon be joined by other responsible physicians who have personal knowledge of some of us and thus help along in this crusade.

M. JAMIL AHMED, M.D.
THE UNIVERSITY OF TEXAS
DALLAS, TEXAS

after 5 years of research and 41,000 patient days of clinical testing

a new infant formula

nearly identical to mother's milk[1] in nutritional breadth and balance

Enfamil®

Infant formula

In a well controlled institutional study,[2] Enfamil was thoroughly tested in conjunction with three widely used infant formula products. These investigators reported that Enfamil produced • good weight gains • soft stool consistency • normal stool frequency

1. Macy, I. G.; Kelly, H. J., and Sloan, R. E.; with the Consultation of the Committee on Maternal and Child Feeding of the Food and Nutrition Board, National Research Council: The Composition of Milks, Publication 254, National Academy of Sciences and National Research Council, Revised 1953. 2. Brown, G. W.; Tuholski, J. M.; Sauer, L. W.; Minsk, L. D., and Rosenstern, I.: Evaluation of Prepared Milks in Infant Nutrition: Use of the Latin Square Technique, J. Pediat. 56:391 (Mar.) 1960.

Mead Johnson

Symbol of service in medicine

Perrin H. Long, M.D.

Editor's Page

EDITOR'S REPORT ON THE KEFAUVER "ANTIBIOTIC" PROCEEDINGS

Since the opening of the hearings by the Antitrust and Monopoly Subcommittee of the Senate Judiciary Committee (The Kefauver Committee), your Editor has followed closely its proceedings. Early in September he spent two days in attendance at the hearings when the subject of the antibiotics was brought to the fore.

To understand these hearings, one must initially become enlightened about certain of the personnel of the Subcommittee, the political aspirations of its Chairman, and the approach to the matters in question by the members (especially the Chairman) of the Subcommittee's Majority. First of all let's take a look at the Senator himself. He was an immaculate fellow during those two hot summer days in his well-pressed blue seersucker suit, his blue shirt, his slightly bluer tie. He was just right for T.V., and did he watch the cameras with his ruddy face taking on senatorial expressions of "concern," "gentle mirth," "deep attention," "anger," "boredom," and "suspicion" as he waved his cigarette holder gracefully or sat in well-posed attentive relaxation. Certainly this was not the coon-skin hat boy! It passed over and over your Editor's mind, "What a hero of the silent films this politician would make!" His two main

assistants—counsel and economist—by contrast, and one could not help but wonder if it was not meant to be this way, were rather unkempt looking people in rumpled clothes and certainly both would be more unalluring on television than in the flesh.

The chief actor in this tragedy (because that's what it actually is) didn't seem to have his lesson well prepared. However, he was brimming over with concern for the "people" (pronounced frequently "peepul"), who had to pay "these prices" for curative and life-saving drugs. Never would he or his staff accept the thought for a moment that the antibiotics, when properly administered, save the patients hundreds of dollars in cost, or even from death itself, over what would have happened had they had the same disease twenty-five years ago.

Ostensibly, this was to be an *impartial* inquiry concerning pharmaceutical trade practices and prices. But it turned out to be, as one could be sure of from the first, an extremely biased and senseless attack on an industry which is intimately concerned with the welfare and survival of the American people.

Your Editor is pretty well informed about this industry and its practices as a result of being a member of the Council on Drugs (formerly the Council on Pharmacy and Chemistry) of the American Medical Association from 1939 to 1960. He avers that the Subcommittee Chairman, Senator Kefauver, has permitted malicious statements to be made, half-truths to be spoken, slanted evidence to be presented, misleading statistics to be entered into the record, and even slanders to be perpetrated by his own staff, and by a parade of witnesses, many of whom were disgruntled ex-employees of the industry (in one instance of the F.D.A.), well-known medical publicity seekers, jealous minor competitors, fuzzy-minded, ivory-tower academicians, and by individuals who from their testimony appeared deep in their hearts to wish to destroy the American system of a freely competitive industry. To be sure, certain well-known emotionally-stable specialists such as Dowling, Meleney and Finland testified in the antibiotic hearings and *in general*

their remarks, which pointed up their own views, can be considered as acceptable. Dr. Dowling's testimony that he would like to see but one "brand" or trademarked name for a drug will be discussed later. As a member of the Council on Drugs, he is in the position to initiate the steps which would be necessary to permit only the first brand name to be considered acceptable for advertising in the publications of the A.M.A. This would have essentially the effect of a Federal regulation in the long run as it would be copied by many journals. With certain exceptions, the Subcommittee's witnesses, like its counsel and economist, were rather pathetic individuals with whom it appeared life had not dealt too gently and who had a bone to pick with the world.

The shooting, if one may call it that, dealt with the matter of prices of drugs and profits derived from antibiotics. It has been known for years that the major companies net from five to fifteen percent yearly on their net sales. However, due to the intense competition and other factors (as for example during the chloramphenicol scare several years ago) net profits may drop by fifty percent or more with astonishing rapidity. It not only takes a top-flight sales organization but also a bang-up research group actively engaged in basic scientific work to keep income at a level which permits of research, development, and educational programs (a lot of money is spent for these) by the drug companies. Then it must be remembered by all medical people (apparently this has completely slipped the well-dressed Senator's mind), that to stay in business, to develop and expand, and to be of real benefit to the people it serves, a pharmaceutical company must make money. It has stockholders who expect a fair return on their investments (actually their returns in dividends have been low compared to the market value of their securities lately), and if they don't get it, they get rid of the management, or their holdings.

Your Editor believes that every thinking physician will agree that antibiotics, when used properly, are curative and/or life

saving and that the savings in costs of illness which their use has brought about, make them cheap in comparison with the situation relative to the costs of having infectious diseases which existed in this country twenty-five or more years ago. Nothing more will be said on this point.

Another part of these hearings was devoted to the "evils" of multiple brand names for the same drug. Well, here the Subcommittee's research group certainly didn't look very far, and the witnesses discussing brand names were either very forgetful or were historically poorly informed. These are the facts. Up until shortly after World War II, it was the policy of the American Medical Association, insofar as advertising was concerned in their Journals (almost all State Journals and certain others followed this A.M.A. policy), to permit the discoverer of a new drug to coin a brand or trademarked name for it and to advertise it under the selected brand name. All other advertisers, if they wanted to use A.M.A. publications for advertising the same product were required to use the *generic name* for the new product. *This then in essence gave the discoverer or inventor of the drug a monopoly as far as brand-name advertising in the total market was concerned.*

Not too long after World War II, certain members of the Council on Pharmacy and Chemistry came to the conclusion that this policy of permitting but one brand-name product to be advertised was restrictive, produced a monopoly, reduced competition, and, possibly, it might involve the Association in certain legal proceedings. After much study and careful thought, the Council recommended to the Trustees of the A.M.A. that the restriction forbidding the use of multiple brand names in advertising in the Association's Journals be removed. After proper consideration, the Association adopted this recommendation. To your Editor, it is incredible that the Antitrust and Monopoly Subcommittee should look so askance at a situation which was designed to break up monopolies relative to drugs and, in our opinion, successfully did so.

Several competent witnesses have suggested that the determination of the efficacy of new drugs and the claims which are made for their use should be passed upon by the Food and Drug Administration. Here again memories are short. Until a very few years ago, the then Council on Pharmacy and Chemistry, using its "Seal of Acceptance" rules as a threat, required that every piece of advertising material and every package insert be submitted to it for scrutiny relative to the claim made for the advertised product. These were carefully studied by the Council referee and his consultants and the claims either allowed or disallowed. As this covered all advertising, whether in publications of the A.M.A. or others, it was effective. But here again, the question was raised as to whether the "Seal of Acceptance" of the Council might not be considered as restrictive and monopolistic and, after a very careful and prolonged legal study of the situation, the use of the Seal was abandoned. The American Medical Association's business office still uses the Council as a decisive body when any questions arise about advertising material. Here again a number of witnesses suggested that a Federal Agency be invested with powers which learned legal talent had considered as being "monopolistic" and "restrictive," if exercised by the American Medical Association. How unclear thinking can become!

Finally, a few words should be said about the attacks made during the Subcommittee's hearings on the role of the so-called detail men. Your Editor has a considerable understanding and knowledge of this group as his son was a detail man for two or three years for one of our leading pharmaceutical manufacturers. He has never knowingly turned a detail man away from his door. They almost always have something worthwhile to say. He is also very much interested in studying them and he considers that they fill a most useful role. Who are these people? Well, most of them are college graduates and some have had education in the basic medical sciences. What do they do? They serve several functions. First, they keep the

physician informed of new products of their company and of new developments relative to established products. Secondly, they provide physicians with new products (samples) and with all types of literature dealing with their company's products. Thirdly, they receive and transmit information about their products from physicians to the medical and/or research departments of their companies, thus helping to add to the general fund of information about the products. Fourthly, as the intermediaries between their companies' research and clinical departments and the doctors, they are in a position to find most of the answers to questions raised by the doctors about their companies' products. Fifthly, certain detail men perform a very useful service in making it possible for physicians to carry out clinical research on their products by arranging for grants-in-aid facilities and material for clinical investigation.

Are these medical representatives or "detail men" salesmen? The answer is, of course they are—but not in the usual sense. You can't buy ethical drugs from them. They are not like the Fuller Brush man who shows you the brushes, takes your order, delivers your brushes, and collects your money. A good detail man keeps his doctors completely informed about his company's products, answers questions, or tries to find the answers, provides all types of service day and night relative to his products, and by his personality, knowledge, and dedication to service to his doctors does his level best to have them use his company's products rather than those of a competitor. As your Editor has seen them over the past thirty years, they are an interesting and very useful group of men.

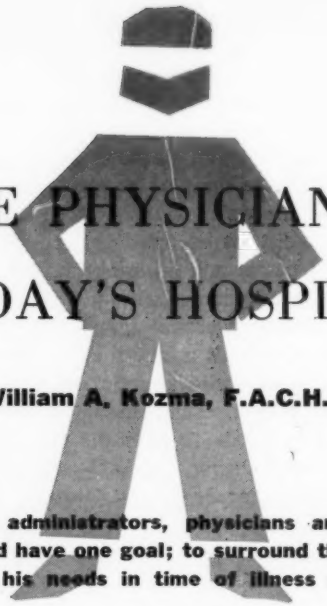
In conclusion, no better summation of these hearings to date can be made than was recently printed in *Barron's* (Vol. XL, No. 37, September 12, 1960) in an editorial entitled *"Remedy or Disease? The U. S. Should Reject the Drug Investigation,"* in which it is stated relative to the hearings of the Kefauver Committee: "As a consequence (of the hearings), with respect to an industry which has contributed so much to its welfare,

the nation stands in peril of swallowing a poisonous brew of misleading statistics, half-truths, and slander . . . the *Kefauver* investigation is not only mischievous but potentially harmful. For to judge by the actions of its chairman, its findings are designed to pave the way for greater federal control over the manufacture and distribution of drugs, possibly including so-called reforms in patent and licensing laws. Such far-reaching changes . . . might easily impede, if not destroy" the remarkable progress of the pharmaceutical industry. "Here, in truth," *Barron's* continues, "looms a cure that is infinitely worse than the imaginary disease. Political quackery may make headlines and, perish the thought, even national policy. It can never serve the general welfare." To all of this your Editor would like to add, *"Watch out Doctor, you may soon be next on the Senator's list! Right after the bakers! They are next on his list!"*

MEDICAL TIMES ARTIST HEADS TB FIGHT

Stevan Dohanos, noted artist, magazine illustrator, and cover art director of Medical Times, sister publication of Resident Physician, has been chosen Honorary Christmas Seal Chairman by the National Tuberculosis Association. Mr. Dohanos was himself stricken with TB in 1932; a brother and sister died of the disease. For many years, he has given his time and talents to support the work of TB associations and other voluntary health agencies and charities.

As National Honorary Chairman, Mr. Dohanos will appear on TV and radio, relate his personal experience with TB through newspaper and magazine stories, and work closely with state and local chairmen.



THE PHYSICIAN IN TODAY'S HOSPITAL

William A. Kozma, F.A.C.H.A.

Hospital administrators, physicians and nurses all should have one goal; to surround the patient with all his needs in time of illness or injury.

No one can dispute the fact that the patient is the most important person in the hospital. All efforts should be geared to provide for his needs. Every group associated with patient care will agree with this premise.

The fact does remain that in spite of this agreement at no time have there been as many problems among all groups administering to patients. We are not, it seems, working together for the ultimate benefit of the patient. In many areas we find ourselves at odds, or giving barely acceptable service.

What has become of the tradition in medicine of devotion to the sick as a prime motivation for those working in the whole field of medical care? At one time, this extended from the medical profession through the nursing profession, the domestics, the orderlies, the techni-

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The author is Administrator of Brookhaven Memorial Hospital, Patchogue, L. I., N. Y.

cians and, in fact, the entire personnel in the hospital.[1]

Serious threat

Today we are facing a serious threat to the voluntary system of hospital care. One has only to pick up his daily paper and read the constant criticism which the hospital business and the medical profession receive as a result of requests by Blue Cross plans for increases. We are accused of mismanagement and of poor admitting policy causing over-utilization. The end result, according to public clamor, is that our combined inefficiency creates higher Blue Cross premiums and higher medical care costs.

That we are guilty to some degree, is apparent. There is room for improvement in hospital organization and administration. But not so great to totally stem the rising tide of hospital costs. There are factors such as inflation, new and costly drugs, etc., which cannot be controlled completely. Equally, there are specific areas where medical staff cooperation can improve the overall pattern of hospital care and costs. In a preliminary investigation by the New Jersey Blue Cross Study Committee, it was shown that, between 1953 and 1958, costs in the "hotel area" of patient care increased by only 18.5 percent, whereas in the medical area they increased by 42.5 percent. The committee concluded, therefore, that "how successfully the administrator can control costs is to a very large extent dependent upon the demands and requirements of the attending physician."

Staff

There is no doubt that the medical staff is the most important part of the organization of the hospital, the smooth functioning and cooperation of which is absolutely essential, if the combined efforts of the hospital and the medical staff are to succeed in fulfilling the mutual obligation to render service to the community efficiently and economically. Appointment of a physician to a medical staff gives him certain rights and privileges; however, it also imposes certain responsibilities and obligations which he must accept. By assuming a position on the staff, he enters into an agreement with the governing body which is an implied contract making him responsible for certain duties in the hospital and for a cooperative attitude toward it and its activities.[2]

That many physicians have not lived up to these obligations is evident. However, they have not been lax to the extent which is featured in the popular press, but definitely to an extent obvious to administrative and nursing personnel in the hospital; obvious also to keen observers such as the Insurance Commissioner of the Commonwealth of Pennsylvania who urged medical societies to institute reforms to eliminate abuses in the use of hospital care.

This laxity is also evident in the findings of a typical survey by the Joint Commission on Accreditation of Hospitals. Too often one can come up with the major deficiences attributable to the hospital's medical staff. True, the major part of the survey involves the work of the physician and achieving a high rating depends to the greatest extent on medical staff cooperation and willingness to accept its full responsibility. The profession of medicine may at times be vocal in its criticism of the program of hospital accreditation because it imposes on the medical man certain "musts" in the discharge of his daily routine. But the thoughtful physician, if he is faithful to his pledge, will in his own conscience have no criticism if he stops for a moment to reflect that the final acid test of a project or program is "the ultimate good for the patient who is entrusted in his care." [3]

Demanding

It is recognized that at no time has the physician been so busy, and at no time has he had to cope with such changing patterns of medical care. His job has never been more demanding, more complex, and never been under such close scrutiny by experts, quasi-experts and run-of-the-mill folk. He finds himself in the unenviable position of justifying his standard of living, his courses of treatment, his ethical standards and hospital practices.

It is not too difficult to see that a great many problems face the medical profession. Some of them start in medical school and others are added throughout life. Some answers are found, but there still remains a great many for which specific therapy has not been found. There can be no doubt that relationships with patients are not as good as they once were. The methods used for creating a better atmosphere between the physician and the general public need a careful overhauling.

Medicine is experiencing a vast number of changes which involve and affect its total structure and operation. Serious inquiry into the motivation, and the nature and the direction of those changes is necessary.[4]

Cooperative work

Some years back the physician recognized that a hospital in the community made it so much easier for him to provide a comprehensive range of health services for all type patients. As a result, medical care is today something considerably more than medical practice. Increasingly, it is the product of a complex form of cooperation between the medical profession, administrators, technicians, nurses and a wide variety of other specialized personnel composing the hospital as a community trusteeship. In addition there has been injected into the situation new forms of community wide financing and planning which further condition the milieu in which medical-hospital services are performed.[5]

The hospital has become a facilitating agency with reference to the practice of medicine and the medical care of patients. As the trend toward greater specialization continues, hospitals are growing still more complex and, in metropolitan areas, much larger. The character of hospital care has been changing so rapidly that hospitals have been hard pressed to provide the facilities and services that are required.

In response to the development of new and more effective methods of diagnosis and treatment, they have had to make available more intensive programs of patient care.

In addition, hospitals now have to admit a larger number of patients who remain a shorter period of time. They also have to render more service to each patient with a substantially increased ratio of personnel per patient.

Thus, hospitals now frequently find it necessary to operate with facilities that were not planned to handle such a large volume of highly specialized services.[6]

Public service

The hospital administrator of today finds himself more and more facing the management problems of a big business. However, he cannot afford, while trying to balance a multi-million dollar budget, to forget that his is a public service organization operated for the benefit of those

in need of medical care. It is for this reason that he needs the cooperation of the medical staff in order to make available to the community the best hospital care at the lowest possible cost. He recognizes full well that his best ally in reaching this goal is the physician, and if the physician is conscious of the hospitals' problems and he can adjust his practice as the need demands there will be greater benefits to the community.

Information

Years ago it was simple for the medical staff to focus its attention solely on medical affairs, but it is not so simple now. We have experienced such remarkable changes in medical science, medical practice and socioeconomics that we find the physician and the hospital with their functions so intermingled that their relationship needs a thorough reexamination.[7]

We appear to be losing our battle at the grass roots for we have not kept the public informed. We have not been successful in getting the public to recognize that hospital and medical care costs more but is worth more. We have not given enough attention in joint effort to promoting the value of the voluntary system of health care. We have passed the public by in the development of scientific medical care.

There can be no doubt that as social financing extends—whether under voluntary or governmental auspices—the interest of the public in the detailed operation of the hospitals will increase. The interest is bound to be expressed through official representatives in federal, state and local governments. It will mean much more exacting systems of hospital inspection and licensure than now exist in any state. The standards now applied under the voluntary Joint Commission on Accreditation of Hospitals will, one day, be adopted by official state agencies.

Control

Equally important, some public agency will sooner or later be set up in every state to exercise control over the construction and location of all hospital beds—not just those built under a construction subsidy program. Otherwise, hospital utilization under insurance, with its resultant costs to the whole public, will not realistically be controllable.[8]

For those who look with alarm at this possibility, one can only say that judicious action by

trustees, administrators, physicians, nurses and others in key positions in medical and hospital affairs may delay or even prevent such steps.

Unless we can obtain and hold the full cooperation of all the medical and para-medical personnel who are active in patient care, unless we can provide medical care of the highest quality to all in need—and in an economical manner, and unless we succeed in these areas very soon, we will find ourselves under some control in the future. Public pressure, whether from people who know all the facts or others who do not, will demand that some form of legislation bring an end to the system of health care we promote. We will succumb to governmental regulation and control.

Direct role

Hospital administrators, physicians and nurses all should have one goal; to surround the patient with all his needs in time of illness or injury. This should be accomplished as a team. The physician with his more direct role in patient care must be more concerned with the problems of the hospital, he must better understand the many forces that affect hospital operations and he must at all times be ready to interpret hospital services to his patients in terms they understand.

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Testing the Foreign Doctor

The ECFMG examination, claims the author, is an example of a procedure which eventually has to be discarded as impractical but which causes quite a lot of damage during the time that it is in existence.

L. Börje Löfgren, M.D.

When new principles were published, outlining the way in which the United States was going to examine foreign medical graduates, this probably came as quite a shock to many European physicians. At a time when some work was being done to extend the range of certain European licenses, America seemingly closed its doors to foreign doctors.

However, this is not the place to argue about the political significance of these measures. Besides, in some respects the problem is not peculiar to the United States. In almost any country I have visited, there are strong feelings about the superiority of the domestically-trained doctor.

If country A and country B both feel that their own doctors are the best, both of them can hardly be factually correct. Some irrational factors seem to be present.

Ability, facts

I would like to discuss the probable efficiency of the proposed ECFMG examination. Certainly it is valuable for doctors to have an extensive knowledge of various medical subjects. However, common sense tells us that

it is not absolutely certain that good theoretical knowledge of various medical disciplines in all instances carries with it a high level ability to practice medicine. All of us know doctors whose lack of wide medical knowledge is little disturbing to them and to their patients. Their good clinical sense tells them where their knowledge is insufficient, and they refer the patient to a specialist in an appropriate field.

Certainly we all know, too, certain bookish doctors whose wide knowledge of often esoteric facts leads them to assign little known and often incorrect diagnoses to various cases.

Still more important, there are extremely skillful doctors whose factual knowledge is great, but whose personal characteristics, such as lack of ethical sense, makes them quite unsuitable to practice our profession.

Thus it can be argued even from a common sense point of view that the knowledge test will not be an infallible selector.

I have used the word *test* in the previous sentence because, obviously, this examination is a test. We could get an idea about its selective efficiency by turning to test psychology. What we find is not very encouraging. Tests designed to show whether or not a

person is suitable for a specific task or occupation are not very exact. One of the most carefully constructed tests, which attempted to select pilots in the American Air Force during World War II, had a validity coefficient of below .7. If the examination procedure used to select acceptable foreign graduates has a validity coefficient of .6, this would be a surprisingly good value. The numerical value of the validity coefficient is deceptive and it is not easy to illustrate what it means.

Measure

If actual medical skill could be measured in some numerical way, we could choose our scale in such a way that the standard deviation of medical skill in a population of foreign graduates would be 100.

Among those who passed the test, the standard deviation of medical skill would then have diminished to 80. Some bad doctors would be weeded out, but also some good ones.

If 1,000 foreign graduates are admitted after testing, there would be some improvement in the average quality as compared to a similar untested group.

However, *the prediction in a single instance from the test results is not very much better than a simple guess.* By and large the selective effect is very moderate.

Influence

This, however, is under the assumption that testing in itself has no appreciable influence on the variation of the medical skill in the population of foreign graduates, an assumption which cannot be taken for granted.

Among the foreign graduates in Europe, for instance, there are some people who are regarded as very skillful, and whose general medical competence is very high. Accordingly, they are offered good jobs in desirable locations.

Still, there are some of them who would like to go to the United States. The reasons for this could be manifold — a desire to get wider views, to use the better facilities for research in this country, dislike for socialized medicine in their own country, the somewhat stuffy atmosphere in some European universities, a liking for the United States.

I have met a few such persons who emphatically declared that, while they had a strong desire to go to the United States, this desire was not strong enough to make them submit to what they regarded as a high-handed and rather insulting procedure.

Thus, it can be expected that some of the very best candidates are simply not even taking the test.

Motivation

The situation is different for graduates who have difficulties in getting suitable positions in their home country. Their motivation to pass the test could be expected to be higher. Some of them might be bad doctors, but good crammers, and some of them would eventually succeed in passing the test. There is a fairly strong possibility that the mere existence of such a test would tend to lower the quality of the graduates who submit to the procedure by cutting away the top men. There is a further possibility that this will in turn lead to the tests being adjusted so that more and more graduates can pass, i.e. standardized for lower average skill.

Recent graduates

So far we have only assumed that medical skill is fairly homogeneous in the population of foreign graduates. However, not all doctors wishing to go to the United States have recently graduated from their medical schools. It is obviously impossible to construct a test that would be effective and fair in testing fresh graduates, and at the same time effective in testing, for instance, specialists with ten years experience in their particular field. Personally I would feel that, for instance, an ophthalmologist who still could satisfactorily answer test questions about gynecology or obstetrics probably could have used his time better in reading ophthalmology instead of keeping up with gynecology. Of course, no really first-class and highly competent specialist would dream of having his knowledge tested in this way. In this way, America will be deprived of some highly competent specialists. Such cases are already in existence.

Quality

It can be concluded that it is in no way self-evident that the application of such a selective procedure will result in high quality in admitted foreign graduates. If the test really is able to select among good and bad doctors, and if the basic reason for its use is to assure American patients better medical care, then it would seem a logical necessity to re-examine all *American* doctors every fifth year or so. No such plans seem to have been considered.

I feel that this examination is

an example of a procedure which eventually has to be discarded as impractical, but which causes quite a lot of damage during the time that it is in existence. One risk is that this type of maneuvering can finally cause federal and state *lay* authorities to take over the task of licensing physicians. The test then becomes a good argument for the opponent to demonstrate what they see as an irrational and politically dangerous attitude in a medieval-type guild of specialists.

Opinions vary whether such a development — that the physicians would lose the right to license themselves — would be good or bad. Personally I feel that this would be an unhappy development.

An answer

At the request of the editors of RESIDENT PHYSICIAN, *Dr. Dean F. Smiley, Executive Director of the Educational Council for Foreign Medical Graduates, read Dr. Lofgren's article in galley. His statement follows.*

I would like to make the following points:

• The founders of the E.C.F.M.G. (the AHA, the AMA, the AAMC, and the Federation of State Medical Boards of the U. S.) are all desirous that the U. S. become more and more a world center for graduate medical education as a contribution to World Medicine and to World Peace.

• The founders of E.C.F.M.G. are equally concerned lest the U. S. become a dumping ground for inept or poorly trained physicians World around. This could negate all the heroic efforts made to raise the standards of American Medicine since 1910, and it could seriously jeopardize the well being of the thousands of patients who would be in the care of these inept physicians.

• Our 360-question, multiple-choice examination in English provides an opportunity to sample the medical knowledge in the five basic fields of medicine, surgery, pediatrics, obstetrics and gynecology and the basic sciences as well as assuring that the candidate understands English. It requires only one day; it is given all over the world; it is machine-scored and is reported on within five weeks after being taken.

• There are medical schools in Europe, the Middle East and the Far East, seven out of eight of whose graduates qualify on our examination without any difficulty. Amongst the 533 foreign medical schools there are, of course, some schools whose graduates do very poorly on our examination with less than one out of eight qualifying.

• It is not expected that a radiologist or an anesthesiologist, or other specialist who has been devoting his time and thought to his specialty for ten years will be able to walk into our American Medical Qualification Examination without any preparation and pass it. Obviously he would have to make at least a brief review of modern texts to bring his knowledge up to date.

• The E.C.F.M.G. has no legal authority and can invoke no penalties for failure of hospitals or foreign medical graduates to comply with its certification plan. Its sponsoring agencies are, however, in position to make requirements, and set up deadlines for compliance and invoke penalties for non-compliance in the form of withdrawal of approval of hospitals or teaching programs. The State Department is in full authority to refuse to extend the Exchange Visitor Visa of a foreign medical graduate for another year.

• It is easy to be critical and difficult to be constructive. The E.C.F.M.G. is meeting a real need. It has already examined 12,011 candidates and qualified 7,474 of them. It makes every effort to help worthy refugee physicians and makes special dispensation for them as regards credentials, fees and the meeting of time schedules.

D. F. S.

NEXT QUESTION, PLEASE

In the Tuckerman will contest in Boston, counsel was attempting to create doubt as to the mental competency of the testator. Counsel addressed the witness, a prominent psychiatrist, with a hypothetical question. The question was 20,000 words long and required three hours for reading. The witness answered: "I don't know."

Second in a series on making your charts complete . . . and legal

What You Should Include in the Patient's Record!

Mary D. Westover

Whether the patient is new, or one on whom you have a full chart, any new or exacerbated syndrome which presents should have these findings *recorded* in your chart:

- Detailed and complete list of both signs and symptoms.
- Recent and past history of significance.
- Lab tests done, with either a copy of the path report or reference to a hospital chart where such report may be found, together with summary of significant findings.
- X-ray films or copy of radiologist's report, or reference to a hospital chart with a summary of radiologist's impression.
- Consultations? If so, give consultant's opinion with observations supporting it.
- Observations re possible psychosomatic etiology.

[Special reports for diagnostic measures (endoscopies, biopsies, smears, etc.), performed by you, will be the subject of next month's article in this series.]

Pediatric diagnosis and reporting differs from adult diagnosis more in emphasis and interpretation than in actual points covered. The diet picture is of relatively greater significance, and developmental factors should be noted and recorded separately from other signs and symptoms.

There is the added factor of parental fears and familial adjustment, and because the report is

usually through a third party, it should be clearly stated *who* gave the information.

Alcoholism

Where acute or chronic alcoholism is pertinent to the etiology, treatment, or prognosis, be as objective as you would in upper respiratory embarrassment. Be *detailed* in recording both signs and symptoms, but make the diagnosis *without* casting any aspersions on the patient by your terminology.

If an accurate and definitive neural determination is precluded by the patient's condition, so state but never in such terms as "Pt. was too drunk to react." That would connote a layman's opinion; a physician should use more accurate, less derogatory phrasing. Handle such a condition, record-wise, much as you would venereal disease. Every detail belongs in your chart—and, of course, the record is completely confidential.

In diagnosing what might prove to be a communicable disease, be sure to note those special signs and symptoms that would establish a differential diagnosis; record *all* pertinent data re time, identity, and conditions surrounding suspected contact (including by whom and how diagnosis was made on contact). *Record* all orders given re prevention of spread of the disease. If there is any type of history re-immunization or treatment for this particular disease, *all* details are significant, and should be recorded.

In handling venereal disease, whether in children or adults, particular care should be taken regarding wording of records and of conversation with the patient.

Phrasing should be completely objective and free from derogatory implications at all times, and *completely* confidential. Comply with all laws regarding reporting, but let it end there. Much of the resistance to treatment in the past can be attributed to fear that the diagnosis would become common knowledge.

If there is a reason to suspect, even remotely, that malignancy is present, you are obligated by law in most states to *complete* your diagnosis with appropriate x-rays, smears, biopsies, etc., so that the patient can rely on the fact that no syndrome has been overlooked, and that every type of pathology present is being treated in the best possible manner for his interests.

Whether the patient is told of the diagnosis is entirely within the discretion of the doctor; but

he has every right to presume that the doctor has definitely determined all the pathology, and that his treatment is based on a provable diagnosis. If for any reason such diagnostic procedures are contraindicated or refused, your chart should state exactly why you did not proceed. Diagnostic information should include:

1. Detailed description of lesion or mass, both externally and at surgery or endoscopy. Include mobility, consistency, presence (absence) of ulceration, etc.

2. Marked vascularity? Fibrous invasion? Nodular invasion? Evidence of extrinsic pressure on another, possibly non-infiltrated viscus?

3. Abnormal bleeding of any type?

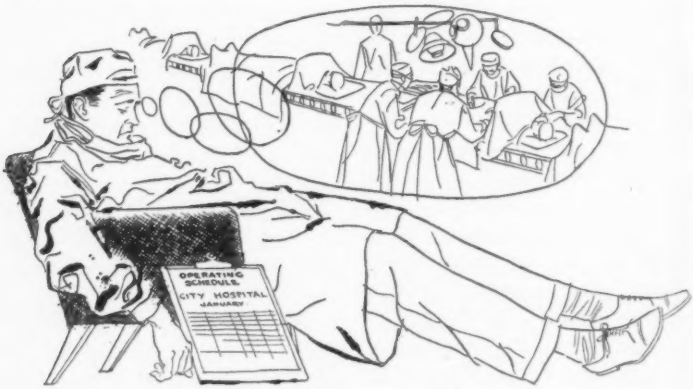
4. Special diagnostic measures (pap smears, etc.) with copy of path report.

5. If biopsied, a statement regarding the extent of the excision; i.e., skin margins, tissue margins, extent of base. If only a definitive specimen is taken, be sure to state that this was the purpose, and that no attempt was made to remove the entire pathology.

6. Frozen section diagnosis, if this was done.

7. Path report on specimen, which should include a definite statement as to whether suspicious tissue was found at the edges of the specimen.

8. If an internal organ is removed at surgery and malignancy is suspected at the time, there should be a very definite state-



ment as to findings, especially those which might suggest either direct extension or metastases.

Medication

When prescribing any medication or medical treatment, your chart should have an accurate notation of what drug, in what dosage, how often, how administered; also include a statement that the patient was instructed (or orders were written, if hospitalized) and also when the patient was to report to you. If there are possible side effects from the drug at the time such report is made, question or test the patient and *record* the presence or absence of such complications.

Whenever you find, either by history or by practice, that a patient is either allergic or sensitive to a drug, make such information *very prominent* in your chart, so that it cannot possibly be overlooked in providing a future summary on the patient.

Many doctors have found it useful to give a patient with a known allergy or sensitivity a typed statement listing the exact drug to which the patient is sensitive. Some put this on the back of their professional card, so that it may be carried with the patient, or be in his possession for future use. Our population is becoming so mobile that this information may be very vital to treatment in another locality. Some patients know their allergies accurately, others are quite confused in reporting them. This shouldn't be left to chance.

Diet

Diet is commonly considered to be a type of medication, and its management is the responsibility of the physician rather than the dietitian. The patient's chart should not only contain the type of diet desired (such as restricted sodium, low calories, etc.) but the specific limitations and pattern of sample meals.

There should be a detailed follow-up on the actual food ingested, including snacks and drinks. This may be kept by the patient or by the dietitian in a hospital. The results obtained from the diet are as much the responsibility of the physician as those of any other medical treatment, and should be *recorded* as carefully as medication. Since these records are not written down by the doctor, but only read and evaluated by him, they are not too time consuming, and often serve to make a patient realize how far he has strayed from the ideal in his dietary habits.

Radiation therapy

In recording radiation procedures, include:

- Pathologist's diagnosis (with stage if possible), date made and type of material on which diagnosis is based.
- Length of treatment period.
- General area of treatment.
- Quality or type of x-rays or modality used; e.g., half-value of x-ray beam, or type, exact amount and placement of radioactive substances.
- Quantity delivered to air, skin, tissues, and/or tumor dose.
- Type and degree of skin reaction, and any evidence of visceral reaction.
- Exact dates and findings on follow-up.

The physician's physical therapy records should show:

- Diagnosis and comparative degree of disability.
- Results desired; e.g., increase in range of motion or strength.
- Precautions to be observed by physiotherapist and patient.
- Detailed prescription:
  a. Frequency of treatments.
  b. Total number of treatments.
  c. Modality (diathermy, exercise, etc.).
  d. Duration and intensity of each modality.
- Results should be accurately recorded every 2-4 weeks.

The physiotherapist's chart should indicate:

- Date and exact time of each treatment.
- Treatment variations, *with reasons,* and *record* confirmation by doctor.
- Untoward effects or complaints.
- Detailed progress notes.

Next Month: Charting examinations and endoscopies.

CARELESS WRITING

The loss to the Hospital through careless writing would be hard to calculate, particularly in medical records, the pharmacy, nursing time and ancillary services. You can contribute substantially toward better service to your patients by writing carefully and legibly. The few seconds you save when you scribble cost the Hospital and your patients days and dollars.

Newsletter of The Mount Sinai Hospital of New York

A **Resident Physician** MONTHLY FEATURE

Clinical Pathological Conference

Methodist Hospital Graduate Medical Center, Indianapolis

PATHOLOGISTS:
Wm. Hurteau
H. Palmer

CLINICIANS:
A. D. Dennison
D. Wilson

A 69 - year - old retired white male laborer was admitted to Methodist Hospital six days prior to death with a diagnosis of depression and pneumonia.

Chief complaints were painful swelling of both jaws, abdominal distention, and generalized muscle pain and fever. Three weeks prior to admission, he noticed weakness of his legs which was followed by weakness of the upper extremities. Also noted was severe constipation requiring large doses of cathartics which were followed by incontinence and deepening depression. Ten to eleven days before death, he developed a sore throat and enlarged, tender, parotid glands. During this same period of time he experienced fever and malaise, and was somnolent. This man had experienced no serious illnesses in the past but had had mumps during his younger years.

Physical examination revealed a well developed, moderately obese, stuporous, white man, who did respond to painful stimulation, especially to palpation of the parotid glands. His skin contained numerous petechia and ecchymosis. These lesions were so numerous on the extremities that they involved the entire surface of the digits in some areas. In the left, lower extremity, there was thrombophlebitis involving old varicose veins. No lymphadenopathy was found. The parotid and ancilliary salivary glands were extremely swollen, firm and tender.

The pupils were small and reacted to light. Extra-occular movements were normal. There was a suggestion of icterus of the sclera. Ophthalmoscopic examination disclosed a moderate degree of sclerosis of the retinal arterioles. The oral mucosa was coated with a gray green exudate which extended into the pharynx. This material appeared to be inspissated secretions. The neck was quite stiff.

The chest was symetrical and there was definite lag of excursions of the right side. Breath sounds were adequate on the left, but none were heard posteriorly below the level of the fourth rib, on the right side. In this region the percussion note was flat and no rales were heard. Fremitus was normal. The P.M.I. could not be palpated definitely, and the heart tones were distant and muffled by the sounds of respiration. No murmurs were heard. The heart rate was 92 per minute, and the blood pressure was 120/80.

The abdomen was distended and tympanitic. A few bowel sounds were heard. The liver was palpable three centimers inferior to the right costal margin and was tender. There was costovertebral tenderness bilaterally. The pulsations in the upper and lower extremities were considered normal. The reflexes were all present and considered physiologic.

Laboratory

Six days prior to death a urinalysis revealed an amber color, specfic gravity of 1.002, alkaline reaction, and a faint trace of albumin with 3 to 4 white blood cells per high powered field. The hemoglobin was 12.1 gms. The hematocrit 41% and the white blood cell count 18,900, with a differential count of 79% neutrophils, 10 stab forms, 1 juvenile form, 6 lymphocytes, 1 eosinophil, 1 monocyte, and 1 atypical lymphocyte. Toxic granulation of

the red cells was also noted Three subsequent blood counts were similar.

Throat cultures on the fifth day preceding death produced gram positive cocci. The spinal fluid contained 8 white blood cells and many crenated red cells. The Pandy was 1 plus, the protein 74 mgs. percent, and the glucose 90 mgs. percent. The gold curve was normal, and preparations for acid fast bacilli and toruli were negative, blood and spinal fluid for syphilis were nonreactive. Routine culture of the spinal fluid was negative. The initial spinal fluid pressure was 130 mm. of water and the first portion of his spinal fluid was grossly bloody. Subsequent specimens were cloudy and xanthochromic. Four repeat blood cultures were negative.

Bone marrow examination was reported as "apparently hypocellular with low numbers of red and white cells precursors and many functioning megakaryocytes; abnormal cells were seen in clumps, probably representing metastatic adenocarcinoma. The impression was infiltration by clumps of abnormal cells in hypocellular marrow." Culture for fungi of the marrow aspired was negative.

Three days preceding death the platelet count was .5 volumes %. The NPN ranged from 180 to 230 mgms. %. A supine x-ray of the chest revealed the presence of a diffuse pneumonic process in the base of the right lung field.

Course

The rectal temperature at the time of admission was 102°, followed thereafter by daily temperature elevations to 100° to 101°. The respiratory rate varied from 45 to 20 per minute throughout the hospital stay. A Levine tube with intermittent suction was used to treat the abdominal distention. Chloromycetin was given initially for three days in doses of 1 gm. intramuscularly every 8 hours. Starting on the first day, 600,000 units of procaine penicillin was given every 12 hours. On the following day, the penicillin dosage was increased to 2,000,000 units every 2 hours and 500 cc of whole blood were given.

In reviewing the physical findings it was noted that a necrotic, ulcerated, pigmented lesion was found on the left heel. By four days following admission to the hospital the nuchal rigidity was unchanged. Coma had deepened and the respiratory rate had increased. A gallop rhythm and uremic frost had developed. The abdomen remained distended and

bowel sounds ceased. There was a diffuse twitching of muscles, and the urinary output decreased. At this time the patient's temperature fluctuated between 99° and 100°, and rales were heard in the posterior right lung field.

The patient died quietly six days following his entrance into the hospital.

Discussion

DR. WILSON: This is a very complicated problem with signs and symptoms in just about every organ system; neurologic, pulmonary, hepatic, renal, GI, hematopoietic and muscular. The general conditions to be considered are the malignancies, the collagen diseases, generalized sepsis with pyrogenic, fungal or rickettsial organisms, amyloidosis, or possibly multiple myeloma with amyloidosis.

The dullness and absent breath sounds would suggest either thickened pleura, effusion or atelectasis, but a lag of the affected side and the x-ray picture would seem to suggest a pneumonitis and I suppose that he had a terminal bronchopneumonia. There were no cardiac signs or symptoms unless his weakness was a manifestation of left ventricular failure. In the absence of significant cardiac disease, the tenderness and enlargement of the liver must be due to either intrinsic masses such as abscess or possibly to obstruction of the biliary tree. The bilateral tenderness in the CVA area suggests renal infection; although an acute arteritis—not an unusual finding in malignant disease—may produce such a picture and lead to a rapidly fatal uremia. The spinal fluid findings of a xanthochromic fluid, a few white cells, a mildly elevated protein of 74 mg. % with normal sugar and nothing found on culture is non-specific.

The purpura was most likely due to the uremia. Rarely tumor emboli give purpura as may the emboli of subacute bacterial endocarditis. Many of the collagen diseases and amyloidosis may give purpura, as may an overwhelming infection, rickettsial disease or non-thrombocytopenic purpura. I would think that this would be unlikely to have been a gram-negative septicema with no more temperature than 101° to 102°F. and with four negative blood cultures.

Rickettsial illnesses give a fairly characteristic generalized rash and a bit more acute course than I believe occurred here.

Rocky Mountain Spotted Fever produces a necrotizing arteritis with involvement of all organ

systems. There might have been a pyogenic endocarditis which could have been missed conceivably on four blood cultures which I assume were drawn before antibiotic therapy. No murmur was heard, but the heart was not well-heard, and there does not necessarily have to be a murmur with subacute bacterial endocarditis early in the disease.

Septic endocarditis might explain the widespread signs on the basis of septic emboli with abscess formation and hemorrhage. There were splinter hemorrhages, but no fundic hemorrhages or enlarged spleen.

Collagen

Amyloidosis will involve in the primary form some or all of the heart, smooth muscle or skeletal muscle. The secondary form will involve mainly the organs below the diaphragm; in other words, the liver, spleen, kidneys and adrenals. I think that we should mention certain of the collagen diseases such as lupus and periarteritis nodosa, both of which may give multisystem involvement with purpura. Periarteritis nodosa usually gives hypertension and eosinophilia. It may produce renal damage, asthma, coronary arteritis and polyneuritis, but generally doesn't fit the picture.

The last major group of diseases to be considered are the malignancies, especially as the microscopist reported in quite positive terms the presence of adenocarcinoma in the marrow. I understand that this is a fairly tricky diagnosis as bizarre histiocytes become more prominent with infection and may be very difficult to differentiate from malignant cells. Multiple myeloma is characterized by osteoporosis, bone pain, kidney involvement and anemia. However, about 15% of the patients with multiple myeloma have an associated amyloidosis and the combination of these two diseases could give a more generalized disease.

The lesion on the heel gives us a good opportunity to discuss malignant melanoma which is a fairly likely diagnosis. The primary lesion here is generally a tumor, having depth and firmness. It usually has an indefinite border, may have a halo of pigment around it and there may be satellite nodules next to it. It is often ulcerated. The location of the lesion is favorable to the diagnosis of malignant melanoma in that they most frequently arise either in the head and neck or below the knee.

A malignant melanoma disseminates more widely than any

other tumor, presumably because of the very poor adhesiveness between the cells and also due to the fact that it tends to cluster around blood vessels, thus giving both hematogenous and lymphatic spread. Any organ may be involved including such organs as the heart and spleen which are usually very rarely involved with metastatic malignancy.

Another tumor to be strongly considered which may present in a strange manner oftentimes is carcinoma of the pancreas. It may present only with a change in bowel habit or development of mental depression. There is usually no significant anemia with this tumor; thrombophlebitis is often associated and often proves to be recurrent or resistant to anticoagulant therapy. There may be a complicating bacterial or a bacterial thrombotic endocarditis with emboli. Purpura may occur as an infrequent manifestation of any carcinoma.

Carcinoma of the pancreas could explain everything except the severe anemia. There may well have been a terminal arteritis which would have given the multisystem involvement and rapidly progressive uremia. My final diagnosis is carcinoma of the pancreas, associated endocarditis and generalized sepsis.

Information

DR. DENNISON: This 69-year-old man presented innumerable complaints including painful swelling of both jaws, abdominal distention, fever, muscular pains and stupor. It is noteworthy that the protocol reveals no family history, no past history, no racial history, and no geographical history. When one is in deep diagnostic trouble some or all of this information may be helpful. It is stated that he was a retired laborer. But did he deal with a noxious type of occupation?

Our problem is a tripartite one. Are we dealing with an overwhelming systemic infection? Are we dealing with a neoplastic process acting in a most violent and diffuse fashion? Are we dealing with one of the various systemic problems such as a hematologic disorder, one of the collagen diseases or amyloidosis?

Are we dealing with an overwhelming systemic infection of which the staphylococcic septicemia is the most prevalent now? He did have fever. He did have leucocytosis. But four blood cultures were reported as negative and spinal fluid culture was negative including the study for torula and fungi. Finally, the bone marrow culture was negative. Nor did the bone marrow study reveal

plasma cells or evidence of histoplasmosis. This latter disease may enlarge lymph nodes, spleen and liver, produce purpura and even implicate the central nervous system.

From the cardiologist's point of view: no murmur was desribed, no pericardial friction rub heard, no clinical or radiological evidence of cardiac enlargement was recorded. Therefore, I do not feel I could make a diagnosis of subacute bacterial endocarditis.

Could this all represent a diffuse hematologic process? No leukemic cells were detected in the bone marrow or peripheral blood. Though purpura was present the platelet count is normal.

Are we dealing with one of the collagen diseases. The pathologists would be lost without this group of diseases to use in CP conferences. But here we find no hypertension, no eosinophilia, no asthma but there was very definitely a terminal renal insufficiency. These features basically mitigate against a diagnosis of polyarteritis nodosa.

Amyloidosis is certainly the great mimic. It can involve many areas of the body, may be a bed fellow with such conditions as leukemia, a lymphoma but especially is related to multiple myeloma. There was no macroglossia, but this is not as reliable sign as previously thought. Nor can the Congo red test be considered as gospel, especially in the presence of albuminuria.

Lesion

Finally did this man die of a malignant process with all the terminal ravages of such a problem . . sepsis, renal insufficiency, widespread metastases, even terminal arteritis? Multiple myeloma may be briefly mentioned. There was muscle tenderness but no bone pain. The urine did not reveal Bence Jones protein, the bone marrow demonstrated no plasma cells and the globulin was not tested for. A statement in the protocol mentioned a pigmented lesion being present on the left heel. Clinicians have long known that such an area may initiate the whole nasty malignant melanoma profile. The disease is more common in females, it can spread in a fulminating manner and metastatic spread may proceed by the lymphatic or hematologic route. Quite significantly the bone marrow report indicated strongly the presence of malignant cells.

The solitary lesion on the heel brings into consideration another malignant process. This is known

as Kaposi's sarcoma or multiple idiopathic hemorrhagic sarcoma. This disease was first described by Kaposi in 1897. It is comparatively rare and has distinctive clinical and pathologic features. Approximately 90% of the patients affected are males. It is most commonly a disease of older people. It tends to produce tender, purplish nodules in the skin. The gastrointestinal tract, lungs, liver, lymph nodes, bones, central nervous system and even the heart can be involved.

The disease tends to affect the laboring class of Italian, Russian, or Jewish background, especially from Central Europe. This disease often is confused with malignant melanoma. Tumors are even seen in the subcutaneous tissues, muscles as well as the spleen and bone marrow. It shares with malignant melanoma a widespread involvement.

In summary, the negative cultural evidence would mitigate against the diagnosis of an overwhelming systemic infection. The unusual systemic diseases such as the collagen diseases and amyloidosis just don't fit clinically here. One gets the impression that we are dealing with a neoplastic process with rather universal spread and terminal sepsis with additional renal insufficiency. Kaposi's sarcoma is the essayist's first choice with malignant melanoma a close second.

Diagnosis

A. D. DENNISON, *attending Clinician:*

1. Kaposi Sarcoma
2. Terminal Sepsis
3. Uremia

D. WILSON, *resident Clinician:*

1. Carcinoma of the Pancreas
2. Endocarditis
3. Generalized Sepsis

1. Acute bacterial endocarditis, Staphylococcus aureus, phage type 52A, 79.

2. Pyemia with multiple disseminated abscesses left lung, myocardium, kidneys, prostate, skin, and empyema.

DR. HURTEAU: At autopsy there was a very striking uremic frost present over the bridge of the nose, eyelids, forehead, and zygomatic processes. This uremic frost could readily be wiped away with a gauze. Small punctate areas of gangrene were present on the terminal phalanx of the thumb and middle digit. A 2 cm. subcutaneous abscess was found in the soft tissues in the left infraclavicular area. The right lung was atelectatic and bound to the chest wall by dense fibrous adhesions. An empyema

Fig. 1. Mitral valve: a large, extremely friable vegetation is attached to the free margin of the valve with extension along the adjacent chordae tendineae.

cavity, containing a purulent exudate, was present on the posterior lateral aspect of the right upper lobe of lung. There were three 1.5 cm. abscesses located in the left upper lobe. These abscesses contained a yellow purulent exudate similar to the empyema cavity. The heart weighed 500 gm. There was fibrinous uremic pericarditis present. A 1 cm. myocardial abscess was present on the anterior lateral aspect of the left ventricle. A large vegetation was superimposed upon otherwise normal cardiac valves. This was a large, relatively smooth, globose vegetation measuring 0.7 cms. in diameter. The vegetation was yellow-gray and extremely friable. It was located on the anterior cusp of the mitral valve, attached to the free margin of the valve with extension along the adjacent chordae tendineae and endocardium (Fig. 1).

The spleen weighed 500 gm. and showed the characteristic extreme congestion of acute splenic tumor. The kidneys were large and were the sites of multiple abscesses, the largest of which measured 5 cm. in diameter. The prostate weighed 30 gm. and was studded with multiple pyogenic abscesses. There was slight cerebral edema with coning of the cerebellar tonsils but no evidence of a pyogenic process within the central nervous system.

Microscopic examination re-

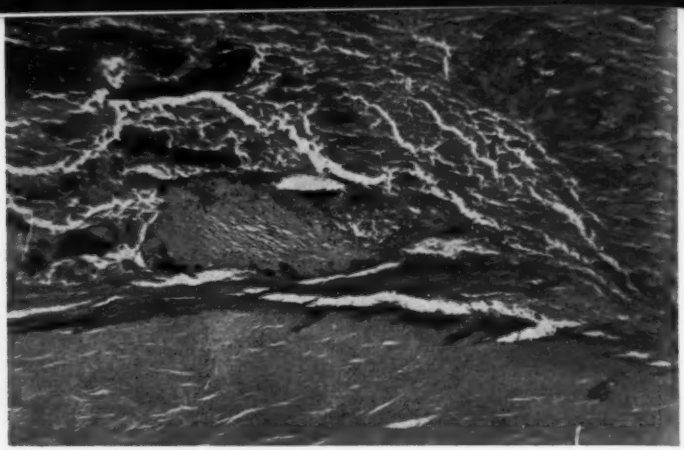


Fig. 2. Mitral valve: the vegetation is comprised of large colonies of bacteria, fibrin and cellular debris. Hematoxylin and eosin (X 100).

vealed thickening of the epicardium due to a fine fibrin mesh over the epicardial surface. The vegetation was comprised of large colonies of bacteria enmeshed in fibrin and cellular debris together with a few polymorphonuclear leukocytes (Fig. 2). There was a characteristic central core of necrotic tissue with overlying fibrin and enmeshed colonies of bacteria (Fig. 3). Within the myocardium multiple abscesses were encountered (Fig. 4). Similar abscesses were found in the lungs, kidneys, prostate and infraclavicular soft tissue (Fig. 5).

The empyema cavity showed early organization of the wall with an acute inflammatory cell reaction in the contiguous lung parenchyma. In the kidneys there were diffuse areas of acute inflammatory reaction in addition to the abscess formation. The diffuse inflammatory reaction was particularly prominent in the renal papillae. The bone marrow was hypocellular with relatively low numbers of myeloid and erythroid elements.

No abnormal cells were seen.

The lesion on the left heel was a benign papillary nevus.

Resistant

Dr. Wilson correctly diagnosed endocarditis and both discussors were correct that generalized sepsis was a terminal event. Postmortem, coagulase positive, Staphylococcus aureus was cultured from the blood, infracla-

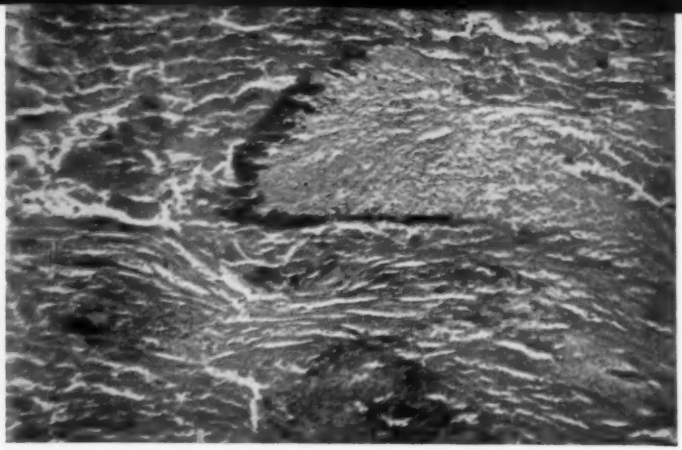


Fig. 3. Mitral valve: a central core of necrotic tissue surrounded by fibrin and enmeshed colonies of bacteria. Hematoxylin and eosin (X 170).

vicular abscess, prostate, and empyema cavity. The phage typing was 52A, 79.

It is of interest that the postmortem culture showed the organism to be penicillin resistant.

The streptococcus was formerly the common offender in acute bacterial endocarditis but in recent years the staphylococcus has become the common offender particularly in fatal cases. This may well be the result of mutation of the bacteria to develop resistance to pencillin and other antibiotics. Certainly in this case, the penicillin therapy would appear to have been adequate. This mutation leads to the selection and persistence of antibiotic resistant strains of staphylococci which contribute to the problem in hospitals and other institutions.

The suggestive portal of entry by history was parotitis, possibly a suppurative parotitis from ascending infection of the parotid duct. The vegetations on the mitral valve were regarded as secondary to the bacteremia, but also in turn, the source of multiple infected emboli and additional abscess formation. The embolization resulted in the clinical findings of multiple system involvement. The relatively low grade fever and leukocytosis were possibly manifestations of little host resistance. The rapid clinical course and the multiple system involvement were compatible with acute bacterial endocarditis.

DR. H. P. PALMER: The antemortem bone marrow in this pa-

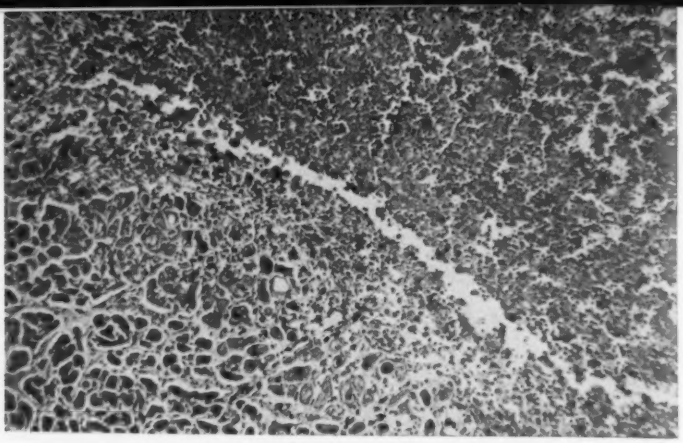


Fig. 4. Heart: margin of emvolic abscess within myocardium showing acute inflammatory reaction with tissue necrosis. Hematoxylin and eosin (X 100).

tient was hypocellular and contained abnormal cells which were interpreted as suggesting a metastatic process. The hypocellularity might be explained on the basis of exhaustion of the bone marrow, debilitating disease, or the most common cause of bone marrow depression, therapeutic agents. The abnormal cells reported were most likely altered histiocytes, a misinterpretation which is occasionally made.

In recent years certain phage types of coagulase producing Staphylococcus aureus have received worldwide attention. It is to be emphasized, however, that phage typing is only an epidemiologic tool and of no use to the clinician as an aid in the management of his individual patient. The clinician's best criteria for determining pathogenicity of staphylococci are whether or not the organism produces coagulase, and more important, its clinical behavior.

Sensitivity

It is of interest to compare the properties of bacteriophage type 52A/79, which this patient harbored, with type 80/81, the so-called "golden staph." Bacteriophage type 52A/79 is known to be a highly pathogenic organism and is frequently a cause of serious staphylococcal lesions. In these respects it differs little from the 80/81 type which is the type most commonly encountered in epidemiologic studies of hospital acquired staphylococci. Although

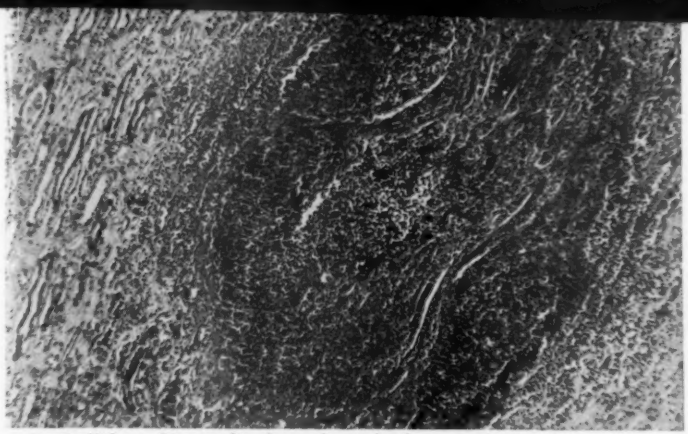
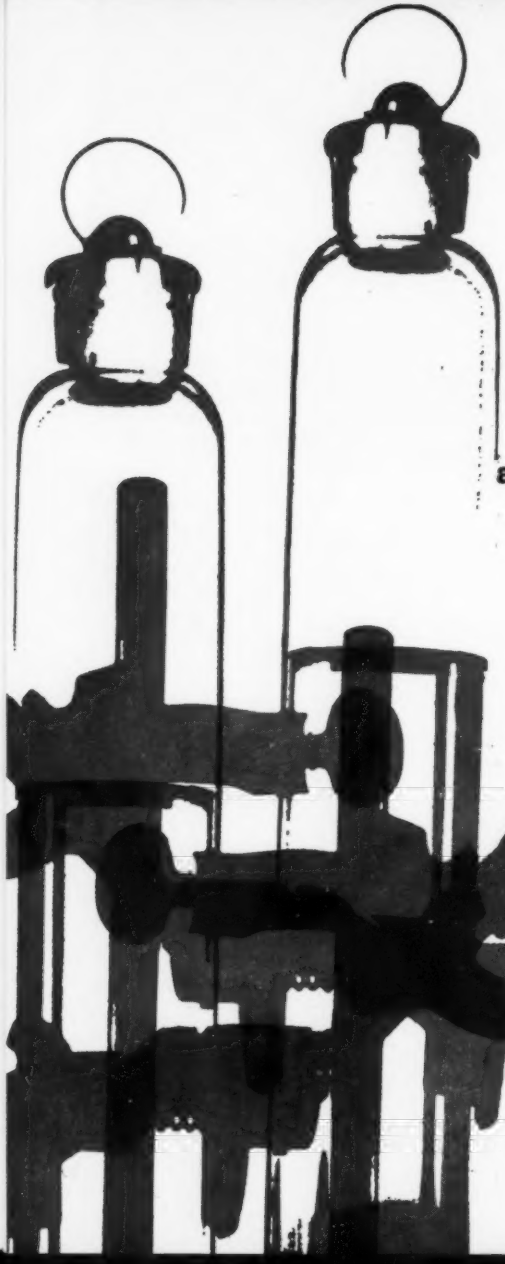


Fig. 5. Kidney: this emvolic abscess located wthin a renal pyramid is representative of the disseminated abscesses present. Hematoxylin and eosin (X 45).

these two types of Staphylococcus aureus differ only slightly in pathogenicity and incidence, there is considerable difference between them when we consider their sensitivity to antimicrobials and their communicability. The 52A/79 type is usually sensitive to several therapeutic agents including penicillin, but the 80/81 type is usually resistant to penicillin and most other commonly used antimicrobial drugs. Also, the 80/81 type is highly communicable in contrast to the moderate communicability of the 52A/79 type. The experience with these two types in our bacteriologic laboratory is in agreement with these findings in that 70% of the 52A/79 type were reported sensitive to penicillin and 72% of the 80/81 type were reported as resistant to penicillin.

Pathogenic

I have mentioned only two of the many types of Staphylococcus aureus, and do not wish to convey the impression these two are the only significant pathogenic types. Staphylococci are widely distributed in nature and all are capable of becoming pathogenic under certain circumstances. The case so well discussed today illustrates graphically the present day devastating effects of the pathogenic Staphylococcus aureus.



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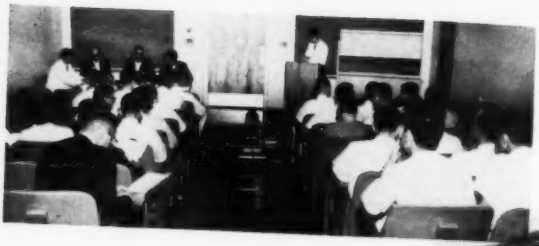
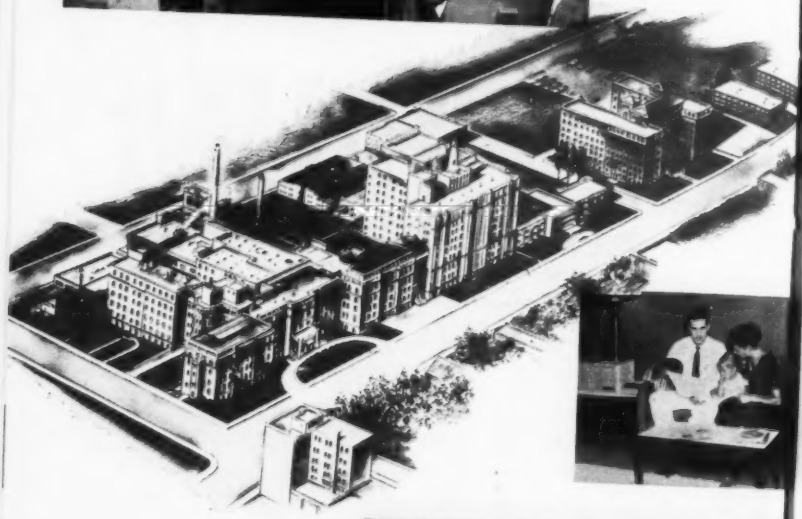
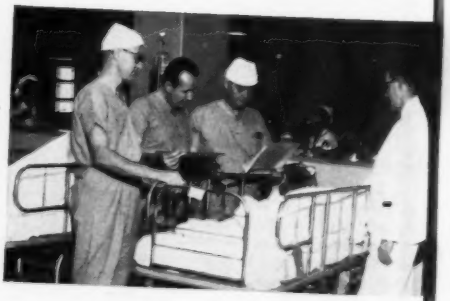






Methodist Hospital Graduate Medical Center

INDIANAPOLIS

The teaching faculty of this 925-bed medical center shares with the administration the opinion that periods spent in furthering one's medical education should be busy, pleasant and without serious financial handicap.

Methodist Hospital is a private, community, teaching hospital with 925 beds, including 108 bassinets. Established in 1899 as a voluntary, nonprofit general hospital, it has grown to become the largest general hospital in Indiana and is fully approved by the Joint Commission on Accreditation of Hospitals. Last year, more than 27,000 inpatients were cared for at Methodist Hospital which has become a diagnostic and therapeutic center for the State of Indiana and a large area of the midwest.

Indianapolis, a community of nearly three-quarters of a million people, is the capital of the State of Indiana and home of Indiana University Medical School, three colleges and one university.

Facilities

Located near the heart of the city and covering an area of more than five city blocks, the Center includes the 925-bed hospital, a research building, laundry, maintenance buildings, two large classroom and residence buildings accommodating 350 student nurses, and two apartment buildings for the house

METHODIST HOSPITAL HOUSE STAFF SCHEDULE

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
7:00 A.M.	Surg. Wd. Rds.	Surg. Wd. Rds.	Surg. Wd. Rds.	Surg. Wd. Rds.	Surg. Wd. Rds.
7:30	Med. Wd. Rds. (Sponsored)	Med. Wd. Rds.	Med. Wd. Rds. (Sponsored)	Med. Wd. Rds.	Med. Wd. Rds. (Sponsored)
8:30		Pre-Natal Clinic, Ortho. Cl.	Gyn. (New-Follow-up) Clinic	Ped. Path Clinic	OB New Patients
9:00	Allergy Cl. & Med. Follow-up Cl.		G. I. & C. V. Clinics (Alternate Weeks)		
11:45	Special Session	Neurology and Hematology Conf. (Alternate Weeks)	C.P.C.	G.U. Path. Slide Conf.	Gross Path. Conf.
12:00	Ped. Clinic		Urology Clinic		
12:30 P.M.					Tumor
1:00	Ob-Gyn Rds.	Ob-Gyn Rds. Ped. Cl. Med. New Pts. Cl.	Ob-Gyn Rds. Diabetic Clinic	Ob-Gyn Rds. Gyn P.P. Cl.	OB-Gyn
2:00	Surg.-New Pts. Cl.	Orth. (Follow-up) Clinic	Ped. Conf.		Surgery
2:30		OB-Gyn Path. Conf.			
3:00	Gen. Surg. Path. Conf.			X-Ray Conf.	
4:00	Surg. Wd. Rds.	Med. Journal Club	Surg. (Lecture-Movie)	Surg. Wd. Rds. OB-Gyn (Lect. Movie)	Surg. Club
5:00		OB-Gyn. Jnl. Club	Intern Jnl. Club		
5:30-6:00	Att. Staff Div. Meeting	Att. Staff Div. Meeting	R-I Dinner Meeting	Att. Staff Div. Meeting	Att. Staff Div. Meeting

SCHEDULE

FRIDAY	SATURDAY
Surg. Wd. Rds.	Surg. Wd. Rds.
Med. Wd. Rds. (Sponsored)	Med. Wd. Rds.
OB New Patients Clinic	
	Medicine Clinic
Gross Path. Conf.	EKG Course (4 Mos.)
Tumor Clinic	
OB-Gyn Rds.	
Surgery Clinic	
Surg. Jnl. Club	
Att. Staff Div. Meeting	

staff. Recently, a new psychiatric wing with 107 beds was added and a 50-bed metabolic ward is in the process of completion, with facilities for special patient education in diets and disease.

Recently completed in the new construction program was an "on duty quarters" for the house staff which includes a recreation-television room, locker room, and individual sound-proofed and air-conditioned sleeping quarters for each person on call at night.

A new air-conditioned medical auditorium, three conference rooms assigned to medical education, and a new medical library provide excellent facilities for medical education.

Training

Since its founding, the Methodist Hospital Graduate Medical Center has endeavored to maintain a training curriculum for physicians, nurses and various technical assistants. Axiomatic in the program is good patient care. This includes 24-hour emergency coverage for all patients in the hospital, a good educational experience for the house staff officer. Duties which, in the opinion of the teaching faculty, are not of good educational experience for the house staff are handled by other personnel. The

teaching faculty represents a wide diversity of training areas, offering the house staff officer with an opportunity for evaluation of different methods of diagnosis and therapy.

The program is organized around a teaching faculty for both private and service cases. The graduate medical education program functions under the House Staff Committee of the medical staff which is responsible for the over-all policies relative to the house staff; a director of medical education who is responsible for developing the educational program and executing stated policies; and an administrative assistant to the director of medical education, who is chiefly responsible for the administrative affairs of the office of medical education and serves as liaison with other departments.

Responsibility

The residency training programs of each section are planned and supervised by their respective educational committees and the director of medical education. Residents at Methodist Hospital Medical Center are given the assurance of continued residency for Board eligibility as long as their duties are carried out in an acceptable manner.

A charity service and a large outpatient service provide interns and junior residents with direct patient responsibility. On the resident level, and in some phases of rotating internship, a preceptorship type of training program is utilized.

Lecturers of note are invited to spend one week in the hospital with the house staff and to lecture to the house and attending staffs on their various specialties.

Stipends, apartments

The monthly stipend for an intern is $225; for 1st year residents, $290; 2nd year residents, $320; 3rd year, $350, and a 4th year resident, $380. In addition, low cost, supplemented housing, uniforms and uniform laundry, meals while on duty, Sunday noon meals for the family, one week paid vacation for interns and two weeks paid vacation for residents are provided by the hospital.

A monthly supplement is given to residents with children: $20 for the first child and $10 for each additional child. "It is realized that families with children incur additional liabilities and, therefore, the purpose of this allotment is to help defray some of those expenses and encourage

self subsistence," the administration reports.

Apartments constructed in 1958 by the hospital on hospital property for the use of the house staff range from efficiencies to three bedroom apartments with two baths. The apartments are attractively decorated, fully furnished and air-conditioned. Play areas are provided for children, both indoors and outdoors. The rent on these apartments is supplemented by the medical center to make it considerably less expensive than comparable dwellings in the city.

Internships

The Council on Medical Education and Hospitals endorses a rotating internship as "the most satisfactory, well-rounded background for medical practice." Consistent with this belief, the Methodist Hospital Graduate Medical Center offers a 12-month program of rotation with three-month periods in internal medicine and general surgery (including orthopedics), two months in obstetrics-gynecology, two months in pediatrics, and two months in the Emergency Department.

The emergency service is active, with 21,794 emergency patients registered in 1959. The intern, responsible for management of this service, has at his disposal the entire resident staff, as well as the attending staff for consultation.

HOUSE STAFF 1961-62

19 ROTATING INTERNSHIPS
34 RESIDENCES:
- 2 General Practice
- 6 General Surgery
- 6 Internal Medicine
- 6 Obstetrics-Gynecology
- 3 Orthopedics
- 4 Pathology
- 2 Pediatrics
- 3 Radiology
- 2 Urology

The intern is primarily responsible for diagnostic and therapeutic management of service cases under the guidance of residents on each teaching clinical service.

In medicine, surgery and pediatrics, the intern is assigned to specific teaching faculty members and also assumes responsibilities for the patients of the faculty. The average intern's load is 15 patients. A program of follow-up care of the patients when dismissed from the hospital in the service clinics as well as many pre-hospitalization evaluations and treatments is designed to

Dr. P. D. White autographing the library's copy of his latest book after a lecture to the attending and house staff.

provide an experience similar to the private practice of medicine. Attending faculty physicians are available as consultants during these clinics to add to the educational experience.

Meetings, conferences

Interns are generally assigned to night duty every third night, leaving time for social activities and study. They are encouraged and assisted in attending district and national meetings in areas of their clinical interest.

Educational conferences of general interest specifically directed to the interns are conducted daily. The special sessions on Mondays deal with problems such as setting up a practice, selective service and social service problems, as well as medical presentations of general interest.

General practice

The program in general practice, under the guidance of Dr. L. H. Martin and Dr. Glen Ryan of the section of general practice, is an elective program of either one or two years offering experience beyond the internship in fields of general medicine, pediatrics, normal obstetrics, simple orthopedics and minor surgery for physicians desiring to enter general practice. Individualized for each resident, program emphasis is on diagnostic, therapeutic and preventive aspects of general medicine as found in general practice.

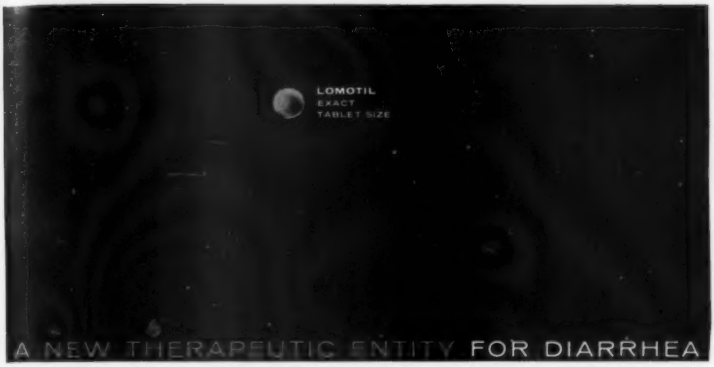
The Methodist Hospital offers a three year program in general surgery under a Type II program as outlined by the American Board of Surgery. The teaching faculty is composed of well trained surgeons who have shown interest and aptitude in teaching, many of whom hold academic appointments at Indiana University School of Medicine. Dr. D. S. Megenhardt is chairman of the general surgery service and Dr. A. R. Madtson is chairman of the education committee for this section.

First year residents are assigned to pathology for three months and to a preceptorship type of training for six months in basic surgery principles. The last three months are spent in plastic and industrial surgery learning the care and repair of tissue. The second year resident rotates through the subspecialty fields in surgery and the third year is spent entirely in general surgery, dividing the time as senior resident and chief resident. During this period the resident performs more than 100 major surgical operations.

Residents in internal medicine are under the supervision of Dr. James O. Ritchey, chairman of the section, and Dr. Robert Pickett, chairman of the education committee in internal medicine. Daily ward rounds are conducted on service cases and formal rounds are conducted with sponsors for discussion of interesting cases three days a week. Management of service cases is conducted by junior residents and interns under the supervision of the chief resident. General medicine clinic two days a week, and a weekly diagnostic clinic are conducted by these physicians.

The second year is spent on a preceptor type of assignment to physicians practicing the subspecialties of medicine. This is supplemented by large outpatient clinics in the various specialties such as allergy, gastrointestinal, dermatology and cardiovascular diseases, diabetes and hematology. Two months of the second year are spent in the radiology and pathology laboratories. Senior residents and the chief resident also work under preceptor assignments and are responsible for inter-service consultation. Conferences, journal club, and basic science meetings are included in the program. Attendance at the Indiana University Medical Center Medicine Grand Rounds is encouraged.

In the obstetric and gynecology program, under the direction of Dr. L. J. Clark and Dr. A. J.



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symptomatic therapy An effective diure (Cardrase†) and a mild tranquilizer (Levanil†) aff symptomatic relief while Provera works to effect a r toration of hormonal balance. They also supplement activity of Provera in those rare cases where restorat of hormone balance does not completely eliminate ede and anxiety/tension.

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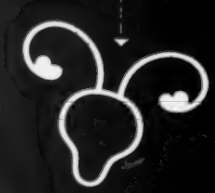

Bachmann, responsibility for the management of normal obstetrics to the serious complications of obstetrics are part of the resident's duties. More than 7,000 patients were cared for under the Obstetrics-Gynecology Service during the year 1959.

Surgical procedures are under the supervision of Board qualified gynecologists, and work with both general surgeons and gynecologists assists in the development of surgical skills in management of gynecology cases. Active outpatient clinics in pre and post partum care, gynecology, and tumor clinics make these an integral part of the training program. A research project is undertaken by each resident.

Orthopedics

Orthopedic training in Methodist Hospital is conducted under the supervision of the section on orthopedics. Dr. David Hadley and Dr. J. B. White direct this program, the first year of which is spent on general surgery and the development of general surgical skills. This is followed by two years in adult orthopedic and operative procedures and fracture work.

A large volume of orthopedic work is conducted by Board certified orthopedists, and experience in correcting congenital and acquired deformities and other chronic disorders, as well as work with the physical medicine department is an important part of the program.

Outpatient clinics at the Central State (psychiatric) Hospital and the Indiana Masonic Home Hospital, as well as at Methodist Hospital broaden this education experience. The fourth year in children's orthopedics can be obtained in the children's hospital in this city.

Pathology

The pathology department is under the supervision of Drs. L. H. Hoyt, E. E. Pontius, Wm. H. Hurteau, P. V. Evans, and H. M. Banks, Board certified pathologists. More than 900,000 examinations by the central laboratory during the year 1959 as well as 305 postmortem examinations indicate the activity in this department. A considerable portion of the teaching responsibilities for the rest of the house staff is vested in this department and it is also an active area for research.

Care of the newborn through all other problems in pediatrics is the responsibility of the pediatric residents. Nearly 10,000 pediatric problems were managed by this section in the year 1959. Super-


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Residents and externs in the air-conditioned house staff recreation room.

vised by well trained pediatricians, clinics, include well baby outpatient, pathology, child guidance, allergy and pediatric cardiovascular. Daily sponsored ward rounds and frequent meetings are a part of the training program in pediatrics developed by Drs. D. L. Rogers and B. S. Roth.

Radiology

Under the supervision of Board diplomates Harold Ochsner, Thomas Brown and Eric Lang, Radiology performed 53,114 radiologic examinations last year. The recent addition of the most powerful cobalt therapy unit in Indiana has broadened the educational program in this department. Plans for addition of a cinefluoroscopy laboratory will soon be completed. Residents take postgraduate courses in radiophysics, radioisotopes and radiobiology at Indiana University Medical Center, financed by the hospital.

Urology

One of the largest urologic services in the country is conducted at Methodist Hospital. Residents are active in the care of service cases and in the management of private cases. Outpatient clinics at Methodist, as well as Central State Hospital and Indiana Masonic Home Hospital are utilized in resident training.

Research work in therapy and development of new diagnostic techniques is constantly being carried on in this department, headed by Dr. William Sutton, chairman of the section, and Dr. J. H. O. Mertz, chairman of the education committee. Attending staff teaching responsibilities are organized in close cooperation with attending urologist, William N. Wishard, secretary of the American Board of Urology.

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Jack A. L. Hahn, M.D.

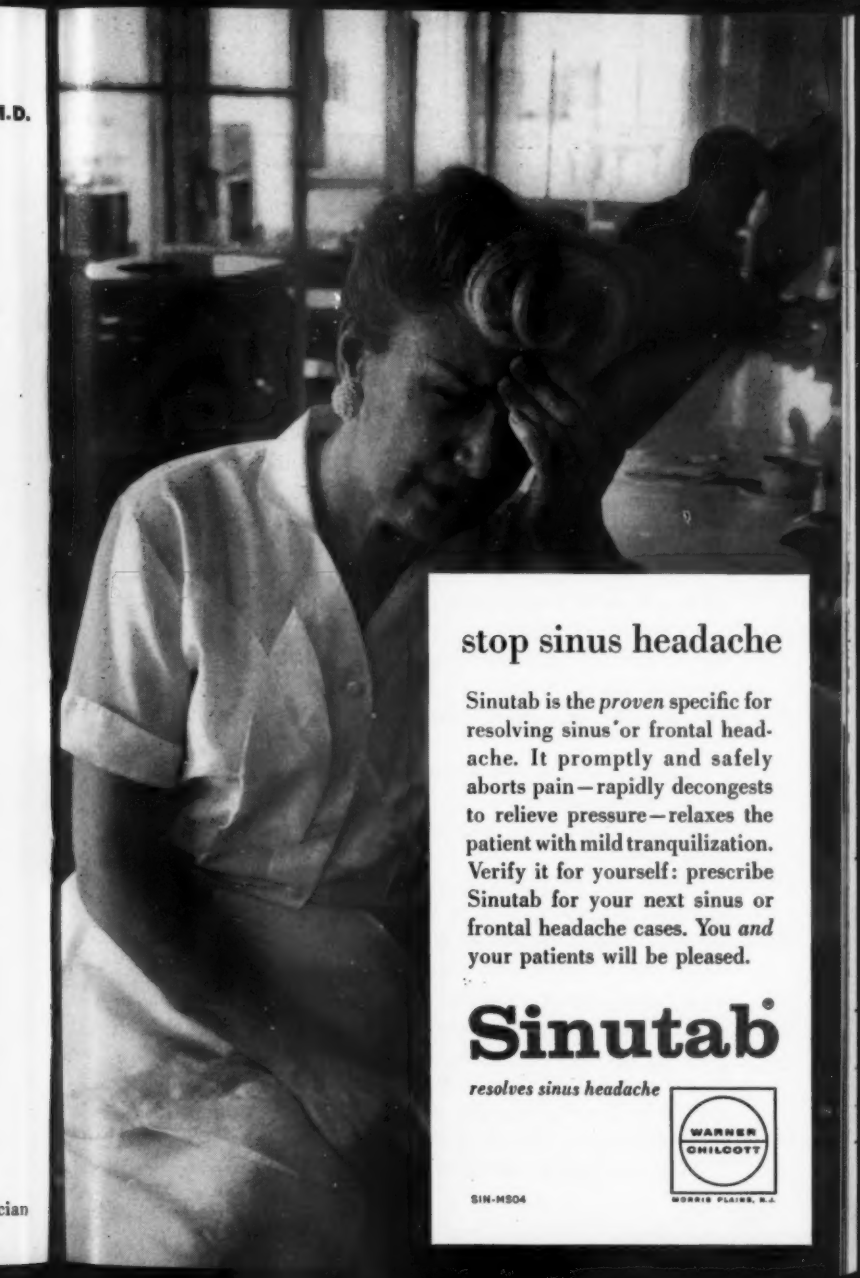
Guest Editorial

The Voluntary Community Hospital— Its Future in Graduate Medical Education

During the past dynamic decade, a greater change in graduate medical education occurred in the voluntary community hospital not affiliated with a medical school than in any other medical teaching facility. This is important as more than one-half of all physicians receive their graduate medical training in this type of hospital.

The years immediately following World War II were a "heyday" for hospitals, with more applicants than residencies and almost enough interns to go around. Programs expanded in number, if not in quality. It was not until the Korean conflict that hospitals had their eyes opened to the fact that program availability had exceeded student supply. This has continued, even though requirements for program approval for the most part have been justifiably stiffened.

The Annual Report of the Council on Medical Education and Hospitals of the AMA (J.A.M.A. Vol. 171, No. 6) still evidences the fact that 20 percent of house staff positions are unfilled. This competition for interns and residents has been the greatest impetus to program improvement in the voluntary hospital, an improvement necessary to meet educational and prestige challenges of the affiliated hospital and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Jack A. L. Hahn, Executive Director, Methodist Hospital of Indiana

the popularity of the public hospital with its large charity service.

There is no question but that elevation and more rigid enforcement of standards had its effect, but the competition motive was a built-in factor of improvement for survival.

Not all hospitals were able to make the essential changes, and many were unwilling to make the sacrifices of time, money and organization required to make graduate medical education in the hospital sound and effective. These hospitals solved their problem temporarily by high stipends and exorbitant benefits, or by filling their service-based program with foreign medical graduates who were often unable to meet either the service requirements of the hospital or to absorb the educational content of even the most limited programs.

These programs are gradually falling by the wayside, and with new standards for foreign graduates requiring ECFMG approval, even more hospitals will be eliminated from the field.

What are the improvements which have been made and the basic assets of graduate medical education in the private hospital? Most important is the acceptance of the concept that both the intern and residency programs are true educational components, essential in the development of a physician. These programs should not be used as a device to provide low cost professional service to the medical staff or to the hospital. This educational concept must be fully accepted by hospital trustees, medical staff and administration if the necessary elements of the program are to be assembled.

Modern hospital administration and leading private prac-

titioners have seen the changes in academic medical education which today places a different kind of physician in the internship role. These changes at the base have required the reconstruction of both internship and residency programs, providing new kinds of learning experiences and progressive responsibility.

The voluntary teaching hospital must provide an adequate number of service patients to give independent opportunity, and provide the organized outpatient experience necessary to give well rounded experience. This is now being done in voluntary hospitals to a greater degree than ever before, and is essential if the voluntary hospital is to remain as a medical teaching institution.

The clinical material in the large voluntary community hospital is both typical and challenging. It will not include a large percentage of chronic patients, but will provide primarily the type of patient who is seen most often in the practicing private physician's office when he completes his training. Although it will not have the large number of unusual patients routinely seen in a university hospital, if it is a large busy institution with a highly specialized staff, it will have a more than adequate number to provide interest and to differentiate between the routine and the complex. The impact of health insurance has greatly changed patient relationships in public hospitals and has added increased medical education responsibilities to the large voluntary hospital.

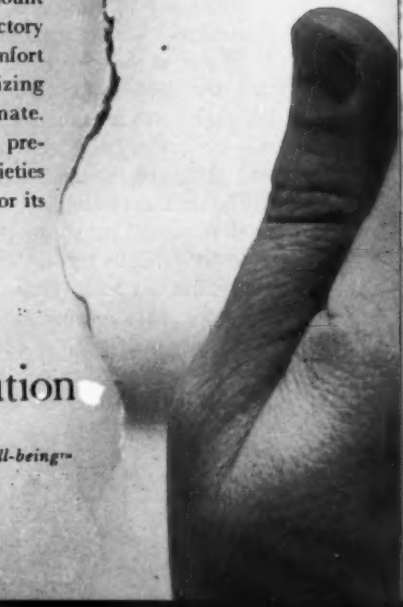
Facilities must be available for study and research. Some of our best medical record departments, medical libraries, laboratories and medical demonstration units are located in nonaffiliated hospitals, and the physician in training must be given time to utilize them in his planned program.

Clinical material, service patients, outpatient departments, facilities, all are important; but the heart of the program lies in the teaching faculty. The word doctor still is defined first as "teacher or a learned man," and although they may not

They can be separated

COMFORTABLE
PREPARTUM
SEDATION

FREQUENT
RESPIRATORY
DEPRESSION
AND HYPOTENSION



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devote their full time to teaching, many physicians in private practice retain the desire and ability to impart their knowledge and experience to others in the profession and devote much of their time and talent to house staff education. To teach at the intern and resident level is both gratifying and stimulating.

The report mentioned above indicates that only 50 percent of hospitals offering graduate medical education programs are approved for both internships and residencies. It is this writer's opinion that, although there are exceptions to the rule, there are inherent values where both programs are offered. Rotation of the intern through clinical services can be better organized and supervised where the service is also staffed with residents, and the resident gains in teaching the intern in the same manner as an attending physician profits in a teaching experience.

Voluntary nonaffiliated hospitals will continue to play a dominant role in graduate medical education. Probably a smaller percentage of hospitals will participate in the future, but those which assume the responsibilities of "teaching hospitals" will function on a much larger scale, and their role will be appreciated with growing prestige to both hospital and physician, student and teacher.

The last decade has proven that you can't have just a small or partial program. A hospital must either make up its mind to get into medical education "all the way" or withdraw from the field. Those voluntary hospitals which choose to accept these responsibilities and which fully meet all the requirements of such a commitment will prove to be outstanding teaching centers, and in turn will be the hospitals of the highest stature and the best in patient care.

Should You

LEASE an Automobile?

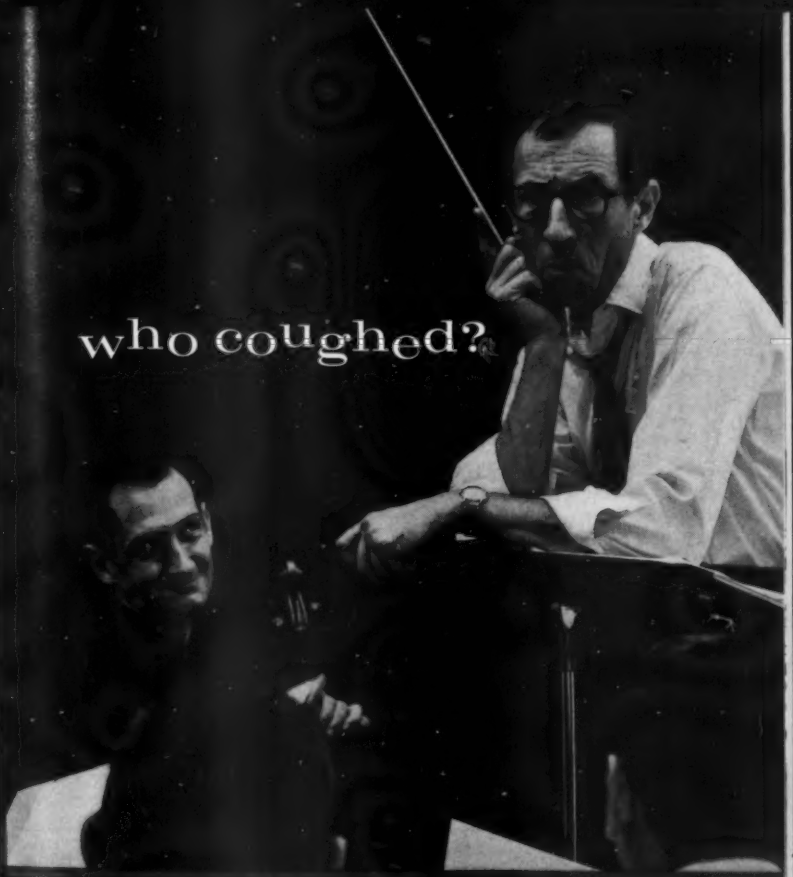
In recent years many doctors have asked their accountants and financial advisors: "Does it make good business sense to rent my car instead of buying it?" If you would normally be buying a new car every two years, the answer, according to the author, is a definite yes.

Joseph Arkin, C.P.A.

It is estimated that 800,000 Americans rented automobiles last year. This includes the drive-it-yourself group as well as the long-term renter.

What are the major reasons for renting rather than buying a car, as stated by the advocates of the lease arrangement?

- Leasing instead of purchasing leaves capital free for other use. No cash is tied up in a down payment.
- While buying an auto on time payments, the individual's borrowing ability is reduced.
- Professional men who use their cars for business reasons are allowed a deduction on their tax returns for the lease payments.
- Bookkeeping and accounting problems are eliminated. No need to keep schedules of depreciation, adjusted trade-in values, etc.
- Cash savings and convenience. The lessor pays *all repair costs,* even where you are at fault. When the automobile is laid up for repairs, another auto-



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Dihydrocodeinone Bitartrate 5 mg.	6.5 mg.
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Pyrilamine Maleate	12.5 mg.
Phenylephrine Hydrochloride	10 mg.
Ammonium Chloride	60 mg.
Sodium Citrate	85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

Literature on request

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COMPARISON: BUYING vs LEASING COSTS

	CHEVROLET FORD PLYMOUTH	CADILLAC
Cost of Automobile	$2500.00	$5350.00
Local Sales Taxes (3%)	75.00	160.50
Total Cost	$2575.00	$5510.50
Interest on financed portion (4%) two years	206.00	440.84
Two-year maintenance costs, repairs, etc. based on official AAA figures	300.00	400.00
Complete insurance coverage*, two years	701.00	868.00
License plates, two years	38.00	56.00
Total costs	$3820.00	$7275.34
Less estimated resale value at end of two years	1000.00	2400.00
Actual costs for two year period*	**$2820.00**	**$4875.34**
Leasing		
Rental cost at $108 per month x 24	**$2592.00**	—
Rental cost at $177 per month x 24 (Cadillac)	—	**$4248.00**
Difference	**$ 228.00**	**$627.34**

*Insurance coverage in examples include $100,000/300,000 public liability, $15,000 property damage, $50 deductible collision insurance, and comprehensive fire and theft.

Items of expense will vary from one section of the country to the other, but costs shown above are representative of metropolitan areas. If the rental costs exceed the deduction for depreciation on owned vehicles, there will be an additional saving of taxes.

mobile is furnished immediately as a replacement. (You don't buy license plates either.)

Chart

A chart is presented here, compiled from figures used by an auto-rental agency in presenting its case to potential customers. Gas and oil costs are not taken into account, as in either event they would be paid by you.

Savings will vary with each individual situation, but many doctors and businessmen have come to realize that serious consideration should be given to leasing. There are sound economic reasons for car rental and that is one of the factors sparking the rapid growth of this service during the past few years.

Not all auto-rental fees are tax deductible as some of the agencies would indicate. To correct an erroneous opinion the Internal Revenue Service issued Technical Information Release No. 159 which stated in part, "Federal income tax rules on this point are quite clear. Auto or truck lease payments are deductible, only if they represent ordinary and necessary expenses of, and are directly attributable to the operation of a trade or business." Professions are also included here.

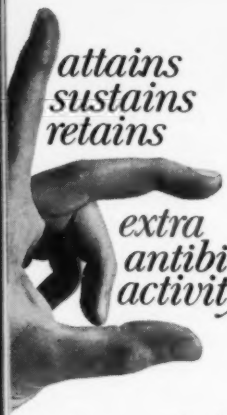
Continuing, "Under no circumstances are such lease payments deductible to the extent they represent personal use by a taxpayer, such as for vacation trips or driving to and from his place of business or employment. And no deduction will be allowed for so-called lease expenses which, in fact, constitute payments towards the purchase price of autos or trucks."

It was also ruled that advance payments must be apportioned over the entire rental period.

Tax position

When the time comes for you to purchase a new car, check the figures in the chart and consider the points mentioned. Then make a decision which will result in cash savings and allow you the most advantageous tax position.

Despite the cash savings shown, the other factors—convenience, lack of worry, credit rating, no tie-up of cash, resale costs and trade-in aggravation—tip the scales in favor of an auto lease arrangement through a reputable agency.



attains
sustains
retains

extra
antibiotic
activity

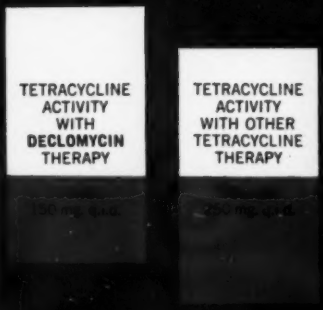
DEC

ttains activity
evels promptly

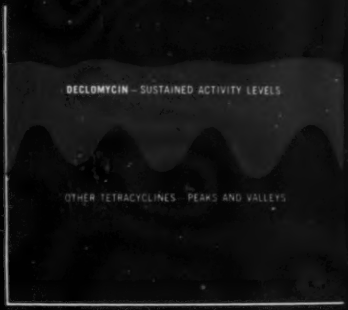
CLOMYCIN Demethylchlortetracycline attains—ually within two hours—blood levels more than equate to suppress susceptible pathogens—on ly dosages substantially lower than those re-red to elicit antibiotic activity of comparable ensity with other tetracyclines. The average, ective, adult daily dose of other tetracyclines 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity levels evenly

DECLOMYCIN Demethylchlortetracycline sustains, through the entire therapeutic course, the high activity levels needed to control the primary infection and to check secondary infection at the original—or at another—site. This combined action is usually sustained without the pronounced hour-to-hour, dose-to-dose, peak-and-valley fluctuations which characterize other tetracyclines.



POSITIVE ANTIBACTERIAL ACTION



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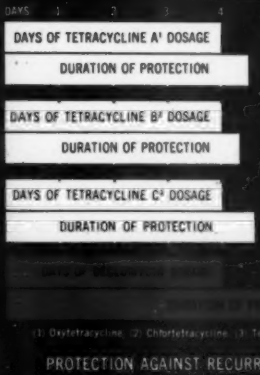
retains activity levels 24-48 hrs.

DECLOMYCIN Demethylchlortetracycline retains activity levels up to 48 hours after the last dose is given. At least a full, extra day of positive action may thus be confidently expected. The average, daily adult dosage for the average infection—1 capsule q.i.d.—is the same as with other tetracyclines . . . but **total** dosage is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 1
Dosage: Average infections—1 capsule four ti daily. Severe infections—Initial dose of 2 sules, then 1 capsule every six hours.
PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bo with calibrated, plastic dropper. **Dosage:** 1 drops (3 to 6 mg.) per pound body weight day—divided into 4 doses.
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PRECAUTIONS—As with other antibiotics, DECL CIN may occasionally give rise to glossitis, st titis, proctitis, nausea, diarrhea, vaginitis or de titis. A photodynamic reaction to sunlight has observed in a few patients on DECLOMYCIN. Alth reversible by discontinuing therapy, patients sh avoid exposure to intense sunlight. If adverse tion or idiosyncrasy occurs, discontinue medica

Overgrowth of nonsusceptible organisms is a sibility with DECLOMYCIN, as with other antibio The patient should be kept under constant observa

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RETAINER FEE

An Answer to Medical Practice Stress

Maurice Levine, M.D.

Here is a suggestion for relieving economic tensions and certain anxieties associated with a large practice.

Out of professional experience with physicians . . . and from casual but revealing contacts with large numbers of physicians . . . there has crystallized the generalization that many physicians labor under a heavy load of external stress and of internal anxiety. Some have the ever present fear that they are not doing as good a job as they should—and a concurrent anxiety that they are not keeping up with the literature, plus a deep concern that they miss matters of importance in individual patients due to the pressure of work.

And one of the major sources of difficulty is anxiety over financial matters. Status in the community, accompanied by expenditures that go with upward social prestige and mobility, plus the constant problem of payments on the house, life insurance, disability insurance and endowment policies, combine to produce a continuing stress situation.

The basic observation, then, is that many physicians engage in a type of medical practice that is

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The author is Professor and Director, Department of Psychiatry, College of Medicine, University of Cincinnati.

When your hospitalized patient is tense and nervous

Stelazine®

brand of trifluoperazine

offers these advantages:

- low daily doses (2-4 mg.) bring prompt relief—often within 24 to 48 hours
- side effects slight and transitory—rarely interfere with therapy
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Because 'Stelazine' relieves anxiety with little or no soporific effect, it is particularly useful for your ambulatory patients: presurgical patients, convalescents, patients undergoing diagnostic tests. On 'Stelazine', they usually become calm, relaxed and cooperative—not drowsy and sluggish.

Optimal dosage: 2-4 mg. daily. Available as 1 mg. and 2 mg. tablets, in bottles of 50 and 500.

N.B.: For further information on dosage, side effects, cautions and contraindications, see available comprehensive literature, *Physicians' Desk Reference*, or your S.K.F. representative. Full information is also on file with your pharmacist.

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seriously stressful, and that tension and anxiety are hidden issues in the lives of many doctors. Unfortunately, one of the most frequent defenses against such anxiety is the assumption of a case load which is too large . . . this in turn serves to increase their anxiety that they may be too rushed to do a good job.

Suggestion

Obviously there are many changes which might be suggested to remedy what is in some respects a most difficult situation. In this paper only one specific suggestion will be mentioned, viz., that a system be adopted in individual private medical practice which would be comparable to the retainer fee system in law practice. This would apply to those physicians who take on a long-term responsibility for patients, e.g., the general practitioner or the internist or the pediatrician, and probably would not apply to surgical practice and to many other fields.

There are comparable plans for a retainer fee or its equivalent in group practice and in certain insurance programs. The suggestion of this essay is that a well-planned retainer fee arrangement is applicable to individual private medical practice, and might solve many of the serious problems of independent practice. Some individual physicians have used some form of a retainer fee arrangement, but the author knows of none who has used it in the form suggested in this paper.

And no such system of individual retainer fees has been sponsored or encouraged by the medical community.

This last item is of importance, since it would be of great value if such a system would become a frequent pattern of private practice in American medicine. If this would happen, no single physician would be regarded as being too interested in financial arrangements.

Monthly

More specifically, the suggestion is that an individual general practitioner or internist or pediatrician should make an arrangement in advance with a patient or family to charge a retainer fee on a monthly basis. Perhaps it would be $10 a month, $120 for the year. If the family remains well and needs no attention for sickness during the year it still

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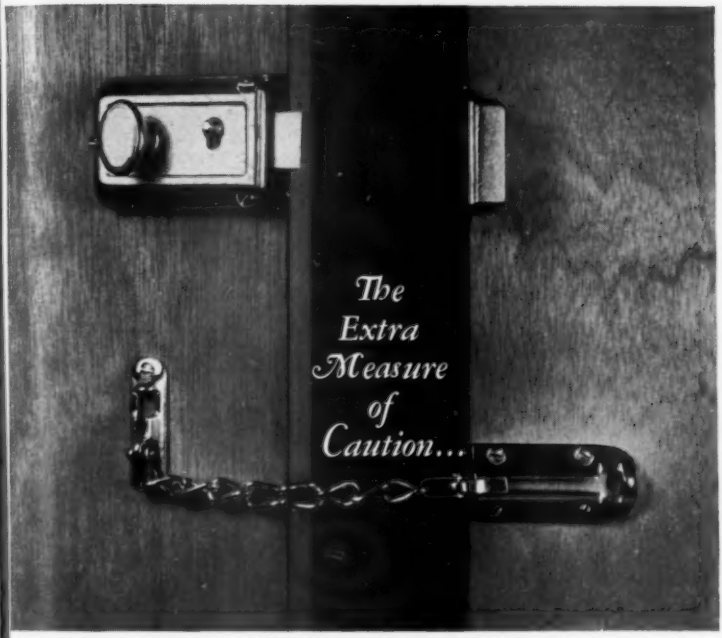
This is the second of two articles. Last month Dr. Levine stated the problem: Stress and anxiety in medical practice.



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would pay this relatively small retainer fee. In return the members of the family would have routine physical examinations and also would have the very great value of knowing with certainty that they can count on having a doctor who would have the responsibility of responding if sickness or an emergency would arise.

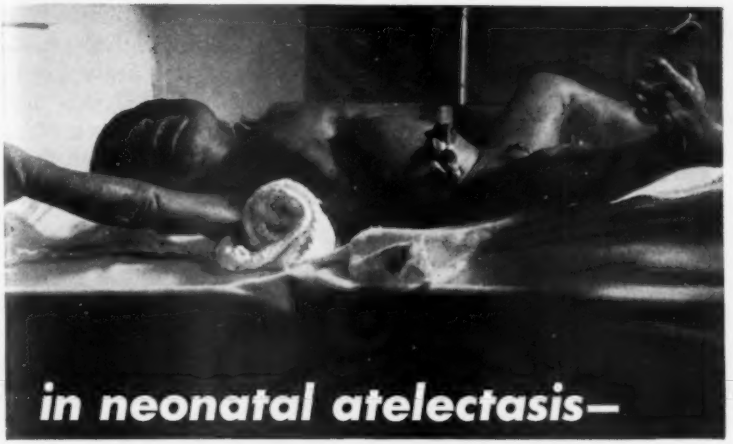
Further, the suggestion would include the idea that the retainer fee would not be the only payment by patients to the physician. When there is sickness in the family that requires more than a minimum of medical care, the family would pay more than the retainer fee. In this way, the system would differ from that in effect in some countries in which the retainer fee is the total ever paid. The combination of a small retainer fee and a modified fee for service is part of the essence of the present suggestion.

The two points of the suggestion so far, then, would be that the family would pay a retainer fee and in addition would expect to pay for service. The suggestion would have a third point, that the family which pays a retainer fee would have the advantage of a percentage discount on the total bill rendered at the time of each sickness. Perhaps it might work this way, that the family would pay the doctor $10 per month if it had no medical attention except for annual examinations. Then, if it did have medical attention during one month, for which the physician under non - retainer - fee circumstances would send a bill of over $10, the retainer fee would not be paid and the bill for the services under the retainer-fee-plan would be calculated with a 20% reduction.

Security

For example, if during the month of January no one needed medical services the family still would send a check for $10 to the physician on the first of February. If, then, during the month of February the family had services from the physician for which the charge ordinarily would be $75, it would, on March 1, pay the doctor a total of $60, i.e., $75 minus $15 (20%) and not include a retainer fee payment.

In a way, the retainer fee portion of the arrangement provides for a basic individual security, for doctor and for patient. The additional fee for service individualizes the situation, permits the doctor to charge what his services are worth, and permits



in neonatal atelectasis—

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"... results are impressive. This dreaded condition usually improved in a few hours, and it was really striking to see a cyanotic baby with gasping respirations and suprasternal retraction become relaxed and pink in such a short period of time."[1]

In the elderly patient with chronic bronchitis "... favorable therapeutic response is obtainable with the use of Alevaire."[2]

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1. Smessaert, Andre, Collins, V. J., and Krecum, V. D.: *New York J. Med.* 55:1587, June 1, 1955.
2. Benoit, A. L.: Geriatrics 14:621, Oct., 1959.

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the family to feel that it is paying for what it gets. Security would be combined with individual initiative and responsibility.

Effective

Certainly in some of the other ethical professions a retainer fee system has been in effect. Lawyers with some frequency charge retainer fees; this is regarded as ethical and completely fair both to the lawyer and to the client. Orthodonists charge an annual retainer fee for their reconstruction work on the teeth of children.

If such a semi - retainer - fee - system were in use in medical practice one might predict that it would be a productive technique of defense or of solution of the anxiety of many a doctor about the size of his practice. Such a solution in turn may lead him to do a more relaxed and effective job with his patients. If a doctor had 100 families on such a semi - retainer - fee basis he would know that he could have an annual gross income of no less than $12,000 ($120 \times 100$). His total gross income, of course, would be much larger. He would know then that it would not be necessary for him to overload his schedule by having too large a number of families for whom he would be regarded as the physician (or internist or pediatrician) and so it would be much less necessary for him to have periods of severe overwork, tension, anxiety, and distraction.

Principle

It should be added, of course, that it may well be that the annual figure of $120 is incorrect, that the figure of 100 families is too large or too small, or that the level of reduction (20%) is incorrect. It may be that a pediatrician should have a total caseload different from that of a general practitioner who deals chiefly with adults. It may be that the size of the retainer and the size of the fee-for-service would depend on the area of the country, the skill and popularity of the doctor, or other factors. The suggestions given above are tentative and given only for the sake of exemplifying the principle. The author has no conviction about the mathematics involved. He does have a conviction that the idea of the semi-retainer-fee system is one possible partial solution of a difficult and significant problem in medical practice. It is the general principle which should be the focus for discussion.

The moot problem of "free

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TRADEMARK

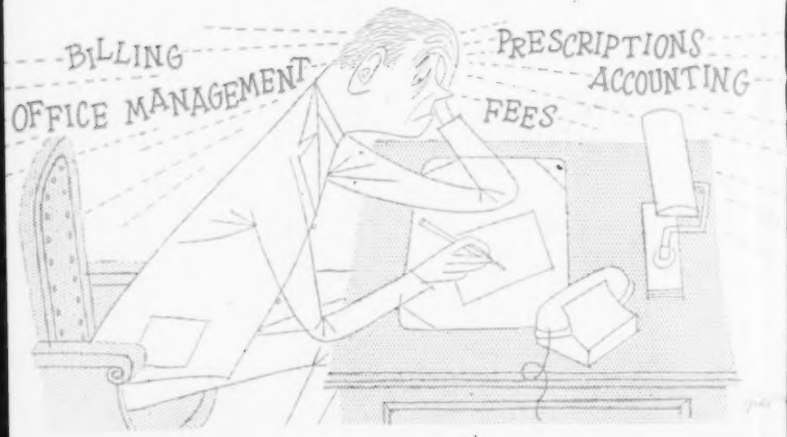
- in mixed vaginal infections
- against secondary invaders in trichomoniasis
- in postpartum care
- after vaginal surgery

Ortho

choice" of doctors is not an issue in this discussion. The understanding between doctor and patient could be that the semi-retainer-fee arrangement would be in effect for a specified period of time, e.g., for six months or for twelve months. The patient temporarily, in a sense, would be giving up his free choice of doctors after he has made a free choice, in that he would agree that he would have Dr. X. as his physician for the coming half year or year as agreed upon. He has the free choice of physicians at the time of the adoption of the semi - retainer - fee arrangement, and again he has the free choice of physicians at the end of the period.

One of the by-products of the development of psychiatry these days is that there is in various disciplines a greater willingness to have a frank discussion of some problems that ordinarily are kept in the background. There must be a clear-cut discussion of medical practice as a serious stress situation, including the various issues of the financial problems of physicians. Money is not merely "filthy lucre." Money is a responsible return for responsible services, a technique for the building of a secure life on the basis of which one can do a more effective and responsible job.

Basic to this essay is the suggestion that there be a reevaluation of the physician as a human being. Many physicians



are idolized as being totally strong, totally competent, totally free of anxiety—and idealized as perfect father figures. The concept that the physician may have some anxiety himself may be repugnant to people in general and to physicians themselves. But now it seems necessary, even urgent, to have a more realistic approach to the doctor as a human being. The author's experience and the experience of most of those who have worked with physicians when they are willing to be frank about themselves, lead to the conclusion that physicians, by and large, are a mature and strong group of human beings. But often even the strongest individuals have anxieties, have problems, have deep concerns. They need not be ashamed of the fact that they are human. In fact it is urgent that they recognize their areas of human imperfection and do as much as they can to remedy or clarify or resolve such problems. And physicians need not be regarded as perfect by their patients. Great strength need not be perfection. Great strength can be associated with some areas of anxiety.

Essentially, this paper suggests that physicians in general admit a truth which does not lessen their strength — the truth that often they have certain anxieties, and that one of these anxieties has to do with their security about their income and their personal responsibilities. The practical suggestion of this essay, then, is that this type of insecurity in part may be resolved on a basis which is totally fair both to a physician and to his patients, by the development of an individual semi-retainer-fee-system, which in fact lessens the anxieties of patients as well as of doctors.

Step forward

Further, under such a system not only may certain stresses and anxieties be prevented or ameliorated, but also other benefits may ensue. Often the alleviation of undue anxiety by a constructive solution is associated with an increase in strength and competence. The personality can function more smoothly and effectively when anxiety is down to an optimal level. Even the learning process, which in medical practice can never stop, goes more smoothly when excessive anxiety in part has been resolved. Such a system, then, may be a step forward in the maturation of the physician and of his patients.

Contest Rules and Prizes

1. Contest will consist of Mediquiz®-type questions to be published in the August, September, October, November and December issues of RESIDENT PHYSICIAN. Contestant must answer and return all five sheets on or before required dates (as indicated in Rule 4) to be eligible.

2. Contestants must have resident physician or intern status and be in good standing in programs currently approved by the American Medical Association and by the American Specialty Board applicable to their specialty. House Officers whose residency or internship status is terminated for any reason *prior* to November 1, 1960, are *not* eligible. Employees of RESIDENT PHYSICIAN or members of their families are not eligible to enter this contest.

3. Each contestant is limited to a single entry each month.

4. *Each monthly entry must be postmarked not later than the 10th of the month following the month of publication, except for contest entries from Canal Zone, Hawaii and Puertò Rico which must be postmarked not later than the 15th of the month following the month of publication.* Each answer sheet must be received by RESIDENT PHYSICIAN by the 30th of the month following the month of publication. Each entry must be mailed

to: MEDIQUIZ® CONTEST, RESIDENT PHYSICIAN, P.O. Box 1960, Manhasset, New York.

5. Questions will be derived by the Editor solely from current issues of medical journals which should be in every approved hospital's medical library. Only journal issues published after March 1960 will be used as source material for questions.

6. Winners will be determined on the basis of the highest total of correct answers.

7. In the event of ties, and at the discretion of the judges, an elimination contest, approved by the judges, will be conducted among those involved in the ties —and will determine the final winners. Final winners will be notified as soon as practicable following the decision of the judges. The decision of the judges will be final.

8. Liability for any taxes that may be imposed on prizes is the sole responsibility of the prize winner.

9. No entry submitted for this contest will be acknowledged or returned nor will any correspondence be entered into with contestants concerning the contest. All entries become the property of THE RESIDENT, INC.

10. Answers will be published in RESIDENT PHYSICIAN after the close of the contest.

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FOURTH PRIZE: **$500**

FIFTH PRIZE: **$250**

Plus five prizes of $100, ten prizes of $50 and 100 prizes of $25 . . . for a total of 120 prizes!

Mediquiz Contest Questions

Here is the fourth set of questions in our $10,000 prize contest for residents and interns! Remember to return the answer card on time!

1. In leukemia, the initial granulocyte response to inflammation:

- **A)** Is composed entirely of immature cells.
- **B)** Would not prove a valuable test for evaluating local inflammatory responses in other disease states.
- **C)** Is both delayed and diminished.
- **D)** Probably plays a very minor role in the susceptibility of leukemic patients to infection.
- **E)** Bears no relation to the peripheral white blood cell counts.

2. Myocardial infarction in infancy:

- **A)** Results most frequently from an anomalous origin of the right coronary artery.
- **B)** If managed without operation has a low case fatality rate.
- **C)** Results in blood being drained from the myocardium.
- **D)** Does not produce a retrograde blood flow in the anomalous artery.
- **E)** Does not produce irreversible changes when conservative treatment is used.

Mediquiz Contest Answer Sheet

Place "X" in correct box in ink

TEAR ALONG PERFORATIONS — FILL OUT AND MAIL NOW ← NO POSTAGE NECESSARY

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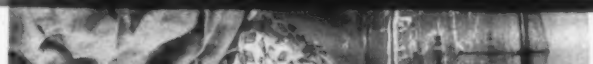

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a pair of cardiac patients:

both are free of pain—but only one is on

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2 mg., 3 mg., and 4 mg.

May be habit forming—usual precautions should be observed as with other opiate analgesics

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MANHASSET, N. Y.

—*Continued from page 40*

she notices any obvious increase in library attendance with this contest.

Best of luck to you and hopes for a successful competition.

MARSHALL N. FULTON, M.D.
PROVIDENCE, R. I.

I too have been very interested in the reading habits of our Interns and Residents over the past years. I think that the physicians responsible for the training of the House Staff are largely responsible for indoctrinating these young men with the proper reading habits, and I have found that the enthusiasm of our House Staff varies directly with that of their teachers. We will be very happy to check with our librarian to see what the results of this contest sponsored by RESIDENT PHYSICIAN does in the way of stimulating the reading of the House Staff.

A. H. MEYER, M.D.

ASSISTANT HOSPITAL
ADMINISTRATOR-MEDICAL
HIGHLAND-ALAMEDA
COUNTY HOSPITAL
OAKLAND, CALIFORNIA

—*Concluded on page 48*

3. Children who have had one seizure of undetermined origin:

A) Should have the seizure treated lightly to avoid emotional disturbances in child and parents.
B) Should be treated with daily anti-convulsant therapy for four years.
C) Should be treated, but medication can be discontinued in six months if another attack does not occur.
D) And who are treated, become emotionally disturbed.
E) And who are treated, frequently have continued seizures.

4. In burned patients to whom growth hormone had been administered during the catabolic phase:

A) Consistent changes in the sodium and potassium balances were noted, co-incident with therapy.
B) A less pronounced effect was noted when growth hormone was given intravenously.
C) The urinary 11 oxycorticoid excretion did not rise.
D) Significantly greater nitrogen and potassium losses were associated with the administration of growth hormone.
E) Weight loss was minimal.

5. Which of the following groups showed the least auscultatory acumen when accurately tested:

A) Third-year medical students.
B) Diplomates of the American Board of Internal Medicine.
C) Interns.
D) Fellows.
E) General practitioners, in practice 10 to 19 years.

6. In a paper on cardiac arrest it was stated:

A) That the older age groups were represented by a higher percentage of cardiac arrests than is usually reported.
B) That the survival rate of those arrests occurring in operating rooms was 15 percent.
C) That ten patients were salvaged by cardiac massage

in arrests occurring outside of the operating room.

D) That cardiac massage is always "indicated."

E) That the overall case-fatality rate in patients was 90 percent.

7. Thirty-nine children, with moderate or severe chronic asthma unresponsive to routine treatment were given oral prednisolone for a minimum of 12 months initially:

A) The response was excellent or good in 7 patients.

B) The initial severity of the asthma was not a decisive factor in discontinuing the steroid.

C) Side effects were important.

D) An insidious growth suppression, long overlooked, occurred in 7 children.

E) The benefits of long-term steroid therapy did not outweigh its dangers in this group.

8. Traumatic asphyxia is characterized by:

A) Its relative rarity.

B) Ease of classical production in animals.

C) Skull fractures commonly.

D) Deep cyanosis.

E) Extensive brain damage.

9. Who produced experimental evidence that the enterochromaffin cells of the stomach and duodenum possess secretory activity similar to the pancreatic alpha cell?

A) Thistlethwaite and Horwitz.

B) Oberhelman.

C) Barbosa, Dockerty and Waugh.

D) Gerber and Shields.

E) Sutherland and De Duve.

10. Recently reported balance studies of magnesium in human beings indicate:

A) With normal bowel and renal function, human beings can tolerate magnesium deficient diets for at least 78 days.

B) Calcium deficient and magnesium deficient states are easily confused clinically.

C) Urine analyses for magnesium by current methods are not helpful in diagnosis.

D) A magnesium deficit rarely

develops in patients with abnormal gastro-intestinal drainage extending over many weeks.

E) Minimally a total of 87 mEq. of magnesium I.M. are needed per week to prevent symptoms of deficiency from developing.

11. BRL 1241, a synthetic derivative of 6-aminopenicillanic acid has:

A) In short-term experiments the property of producing significant resistance in staphylococci.
B) No cross sensitivity with other penicillins.
C) Long-lasting action as it is excreted very slowly.
D) Considerable resistance to the action of penicillinase.
E) Has a strong bacteriostatic action against Staphylococcus aureus.

12. Strenuous exercise and training results in the following effects in known athletes:

A) Increases the morbidity from coronary disease in later life.
B) Decreases life expectancy.
C) If carried to exhaustion is said to provide definitely improved athletic performance.
D) Produced a deficiency in pulmonary function.
E) Was injurious as far as real increase in regional muscle group strength is concerned.

13. Tight mitral stenosis without diastolic murmurs may be present when:

A) There is massive infarction of the right ventricle.
B) Fungating vegetations are present on the mitral valve.
C) There is massive thrombosis of the left atrium.
D) Aortic insufficiency is present.
E) An accentuation of the first sound is absent.

14. In a study of vascular disease in Trappist monks it was noted:

A) That their diets were extremely low in fat.
B) That they had not been spared from arteriosclerosis and hypertension.
C) That they have higher cho-

lesterol levels than Benedictine monks.

D) That blood donors in Amsterdam had lower cholesterol levels than Trappist monks.

E) That the lipoproteins in the —S-40-70 range were higher in the controls.

15. In a recent study of gastro-intestinal bleeding in cirrhotic patients it was found:

A) That bleeding was not associated with the degree of hepatic compensation.

B) That bleeding appeared to be accidental in the course of the disease.

C) That bleeding is not associated with acute alcoholic bouts.

D) That bleeding is frequently from sites other than varices.

E) That esophagoscopy is the single most dependable aid in the diagnosis of bleeding varices.

16. In a recent study of isoenzymes and myocardial infarction it was noted:

A) That lactic dehydrogenase activity of human plasma consists of the sum of four isoenzymes.

B) That cardiac muscle contains isoenzymes LD_3 and LD_4.

C) That there is a relative or absolute decrease in the three other plasma isoenzymes.

D) That diseases of the liver, etc., cause similar changes in plasma isoenzyme patterns.

E) That LD_3 increases for five to ten days during the initial phase of myocardial infarction.

17. Who of the following is designated as one of the five pillars of Surgery by Warren H. Cole:

A) William Hunter.

B) W. W. Keen.

C) Theodor Billroth.

D) René Leriche.

E) Ambroise Paré.

18. In a recent study of sexual activity and fecal continence in patients having acquired megacolon it was noted:

A) That the mechanism by

which potency is reduced in the male and lost in the female is unknown.

B) That there is a direct relation between the level of anastomosis and fecal continence.

C) That following operation, recovery of full sexual activity is rare.

D) Fecal incontinence persisted post-operatively in most of the patients.

E) That the abdominoperineal resection of the rectosigmoid produced adverse effects in most patients.

19. It has been recently observed that thoracic-duct lymph in patients suffering from cirrhosis:

A) Shows a decreased volume of flow in the thoracic duct.

B) Shows an increase in flow rate after porto - caval shunt.

C) Shows a lowered sodium concentration after inferior vena cava obstruction.

D) Shows enough intact red cells to make the lymph look hemorrhagic.

E) May contain a preponderance of polymorphonuclear leukocytes.

20. Acute upper gastro-intestinal tract hemorrhage in patients sixty-five years of age or older:

A) Is generally caused by a malignant lesion.

B) Is best treated by emergency gastric resection.

C) Does best if left alone.

D) Should be treated if massive, by emergency subtotal gastrectomy, if not arrested by adequate transfusion therapy.

E) Is characterized by a good patient response to prolonged blood administration.

MEDIQUIZ® NOTE

Due to a typographical error in Question #2 in the October *issue, all contestants will receive credit for a correct answer to that question.*

Fifth of a series on various specialties

Equipping the Ob–Gyn Office

If you're not on a limited budget, you can pull out all the stops. But if your budget is limited by your credit at the bank, plan carefully, compare costs and features of similar items. The money you save will be your own.

An office for the practice of obstetrics and gynecology is unique in at least three respects:

1. The practice deals exclusively with women.

2. The woman patient returns to the office at regular intervals.

3. The OB patient often becomes clumsy as the pregnancy progresses.

All three factors mentioned indicate that the waiting room is of great importance. First, it should have feminine appeal—not as a boudoir, but like a living room in the home.

Everything about the waiting room should be subtle, relaxing, and in a quiet harmony of color and design. From the pictures on the wall to the placement of the lamps and the lighting arrangement, the waiting room should invite the patient to enjoy the comfort of the surroundings.

Although most men appreciate "pretty things," women insist upon them. Also, a man might sit on an uncushioned chair in a barbershop for 20 to 30 minutes without complaint. A woman, especially a pregnant woman, wouldn't put up with this without grumbling. Straight-back chairs?

"All my 'diet' patients get an extra lift with 'Beminal' Forte"

in the special diet patient improve nutrition... promote better health with

BEMINAL FORTE

Therapeutic B Factors with Vitamin C

A single capsule provides 250 mg. of vitamin C and massive doses of B factors to meet the need when requirements are high and reserves are low. Prescribe "Beminal" Forte for patients on special diets, pre- and postoperatively, and during convalescence, to improve the prognosis and accelerate recovery.

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Yes. But *not* hardbottom chairs. Nor will overstuffed chairs into which the average person would sink with a sigh of content be acceptable to the mother-to-be. Besides being uncomfortable, your patient would need a derrick to help her up again.

Selection of furnishings should be made with ease of maintenance and cleaning in mind. A woman has sharp eyes and a quick tongue. Dirty ashtrays, dog-eared magazines, soiled chairs or drapes, even dust; all are subject to her critical measure. Her "clinical impression" may make her first visit her last.

Waiting room

In previous articles, mention was made of plastic and leather-covered furniture. According to our survey, the majority of obstetricians prefer plastic-covered chairs. Although originally, a number chose overstuffed furniture, most admitted their mistake, agreed that pregnant women were uncomfortable in the very soft, deep chairs.

The cost of an attractive plastic chair is from $30 to $50 and the minimum number required is six. (The husband may come on the first visit, but after that he is happy to wait in the car.) Overstuffed chairs are more expensive, prices ranging from $75 up.

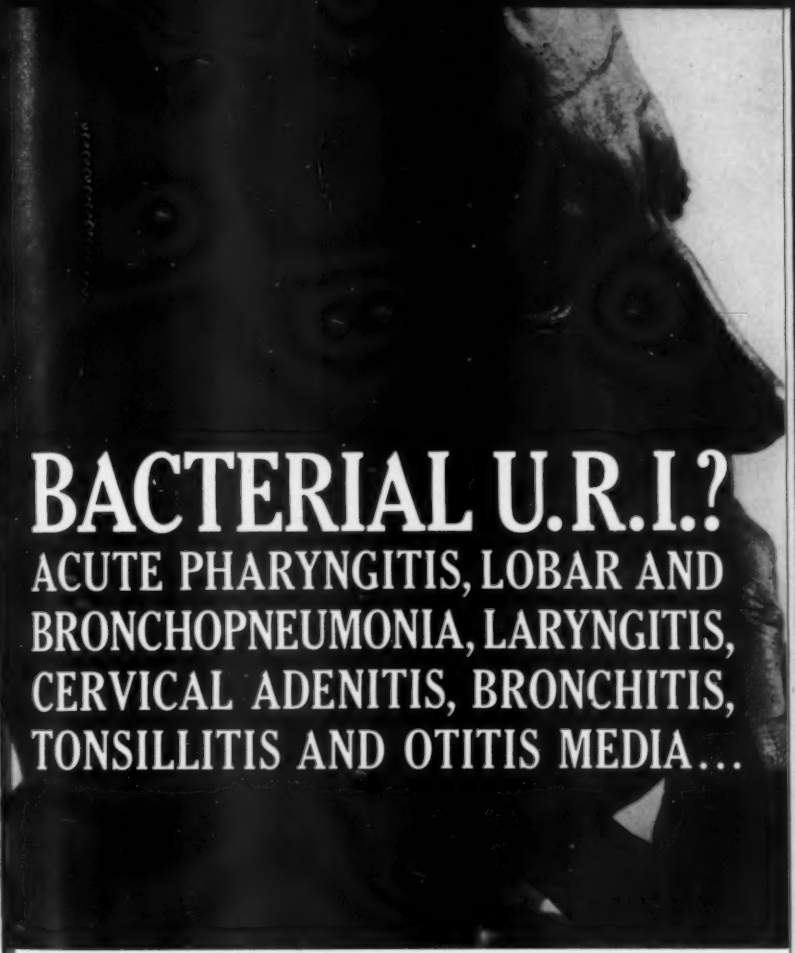
What equipment is needed in the beginning practice of obstetrics and gynecology? RESIDENT PHYSICIAN *recently put this question to a number of practicing ob-gyn men. Based on their answers, this article is presented as a guide to those residents who will soon be setting up a practice in the specialty.*

Carpeting in the waiting room was preferred by most respondents, their reported cost varying from $8 to $15 a square yard, installed.

Table lamps and floor lamps were chosen in preference to wall lights. Since patients sometimes wait long periods in an obstetrician's office, the lamps should be chosen not only for their attractiveness, but for the amount of illumination they give. Cost of a good lamp is at least $25.

Tables are needed for ashtrays and magazines, and can be bought for $35 up. Incidentally, get large ash trays, preferably those that can be emptied easily.

A few obstetricians took into consideration that many of their patients have small children who



BACTERIAL U.R.I.?

ACUTE PHARYNGITIS, LOBAR AND BRONCHOPNEUMONIA, LARYNGITIS, CERVICAL ADENITIS, BRONCHITIS, TONSILLITIS AND OTITIS MEDIA...

BEFORE YOU WRITE FOR AN ANTIBIOTIC CONSIDER THE 'PLUSES' OF NEW ALPEN FOR YOUR PATIENTS!

Alpen is more active against clinical isolates of penicillin-resistant staphylococci than older penicillins.[1] Alpen is indicated for acute and chronic streptococcal infections. Alpen is rapidly absorbed to produce high blood levels. Alpen has greater freedom from the G.I. sequelae of the broad spectrum -mycins.

ALPEN

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1. Norgi, E. M. E.; Wheatley, W. B., and Albright, H.: Antibiotics Annual 1959-60, N.Y., Antibiotic, Inc., 1960, 131.

Schering

accompany them to the office and so have a few small chairs and books available for the tots. Cost: from $5 to $15 a chair.

Consultation room

The consultation room for the obstetrician poses no special problems except that it should be as completely soundproof as possible. Rugs, drapes and special ceilings assist in this purpose. The decor of the room should be dignified, but not severe. It should tend to invite conversation.

For the cost of the desk our informants quoted prices of $75 to $300, depending on size and type.

Chairs varied from $75 to $150 for the physician's chair and $35 to $50 for the patient's chair. Some obstetricians have no third chair. Said one, "If I let the husband stand during our conversation, he generally has few questions, leaves quickly."

While many busy obstetricians have two or more examining rooms, a single unit is considered adequate for the beginning practice.

A table of course is required. Two main points to be considered are its strength and ease of manipulation. A new table can cost as little as $125 or as much as $700 to $800. The average price quoted in our survey was $300. Stirrups should be attached and should be simple in operation. Some tables come equipped with electrical outlets and basins. These are valuable features according to our survey group.

A small, sturdy stool for mounting the table should be available. It should cost no more than $15 to $20, but make sure it's as slip-proof as possible.

A head light is required. The shadowless model with a wide base was preferred by the majority of responding obstetricians. Some indicated a preference for one that attaches to the wall.

A treatment stand and cabinet are necessary to hold the many instruments and speculums needed. Both may be purchased for under $200.

Since these rooms are used so

frequently, special care should be taken in furnishing them. The dressing room should be separated from the lavatory and adjacent to the examining room. It should be well-lighted, have a seat and a mirror. Hangers and hooks should be supplied for clothing and gowns. The door should be able to be locked from within. The total cost of dressing room equipment is usually less than $75.

The lavatory, aside from being readily available to both the waiting room and the examining room, should contain a wash bowl, stool, a mirror, shelf, waste basket, soap and towels. Your nurse will have access to sanitary items and will make this known to each patient.

Instruments

Either a sterilizer or an autoclave or both will be needed. A new sterilizer costs from $35 to $100. Autoclaves run from $220 to $550. Respondents were divided in their preference.

Special instruments are required by the obstetrician. An electric cautery is important and the cost of one suitable for the ob-gyn man can cost up to $350. An apparatus for tubal insufflation is required at a cost of about $150. A bloodpressure device,

preferably one that can be mounted on or near the examining table, will probably cost in the neighborhood of $50.

Other instruments such as forceps, speculum, ring sets, etc., can usually be purchased for under $150 for the lot. This sum includes the drugs that the obstetrician needs handy. A scale can be purchased for under $50.

A microscope, if not already available, is necessary—cost will be about $250 to $300 new and $175 second hand. Other lab equipment for the simple CBC, sedimentation rate and urines will cost about $100. More extensive lab facilities aren't needed by the beginning obstetrician, according to the panel.

In summary, the total cost of office equipment of those responding to the RESIDENT PHYSICIAN survey was as little as $2000 to a bit over $4000.

Hard filled capsules in bottles of 30.

4 mg.

Medrol* Medules†

pH-patterned slow release...

not here at pH 1.2

In the relatively acid medium of the fasting stomach, Medules are kept essentially intact by their special pH-sensitive coating (about 5% of Medrol content released in 2 hours at pH 1.2).

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In the environment of the duodenum (at pH of approximately 7.5) 90% to 100% of the Medrol content is released within 4 hours.

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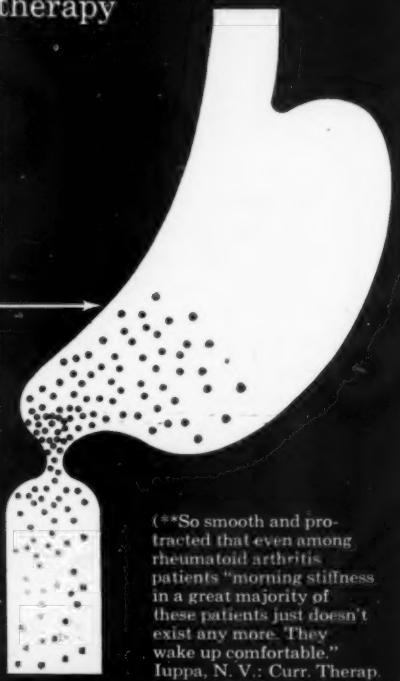
135 tiny doses mean smoother** steroid therapy



(**So smooth and protracted that even among rheumatoid arthritis patients "morning stiffness in a great majority of these patients just doesn't exist any more. They wake up comfortable." Iuppa, N. V.: Curr. Therap. Res. 2:177 (June) 1960.)

*Trademark, Reg. U. S. Pat. Off — methylprednisolone, Upjohn

†Trademark

Medrol hits the disease, but spares the patient

Key Words for the Clinic

In many areas of the U. S., foreign-born comprise a large part of the total population. Hospital physicians when examining and treating foreign-born patients, many of whom speak little or no English, often encounter serious difficulty in communicating even the most routine request or direction. The result is not only frustrating for doctor and patient, but a misunderstanding can endanger the proper care of the patient. To ease the patient's anxiety and assist the physician in conducting an accurate examination and history-taking, RESIDENT PHYSICIAN has prepared this guide to commonly-used medical directions, questions and answers, with translations into various foreign languages.

Using the language guide

Keep this language guide open in front of you while attending your patient. If a word doesn't seem to be understood, repeat it a few times slowly; vary the pronunciation slightly until the patient indicates his comprehension. The fact that you are trying to speak to him in his native language will cause your patient to be more relaxed and responsive. Grateful for your effort, he will be anxious to do everything he can to comprehend and convey accurate, precise information.

FOR EXAMINATION OF

French-speaking Patients

Rules of pronunciation

a is pronounced *ah,* as in father: *la, bras.*

é, as in *café;* année, appétit, été, diarrhée, nausée.

è or ê, as in *pet;* près,

e (without accent mark)—At the end of a syllable, pronounced like e in *the* (thuh): le, se, sera. Before a silent consonant, pronounced life é in *café;* avez, nez, poussez, toussez, respirez, ouvrez.

i, as in *police:* petite, facile, appétit, urine. Before another vowel, i becomes like *y* in *yes:* pied, fièvre, combien.

o, followed by a double consonant, as in *some, done:* donne, somme.

ou, as in *ooh, cool:* ouvrez, jour, vous, bouche.

ai and ei, as in *said:* mains, haleine, connaissance.

Final consonants, whether single or in groups are silent except c, f, l, and r. Silent: doigts, pieds, estomac, mains, fois, nuit, dos bras. Sounded: laxatif, jour, mal.

Courtesy

NOTE: The courtesy titles *Monsieur* (Sir), *Madame* (Mrs.) and *Mademoiselle* (Miss) are used freely. Also, the expression *s'il vous plait,* (see-voo-pleh) meaning *please,* is always used at the end of any request or direction given the patient. *Merci* (Thank you) is another word which should be used frequently. Courtesy words are omitted here for the sake of brevity.

Good day (hello)	Bon jour
Good morning	Bon matin
Good evening	Bon soir
Goodbye	Au revoir *(oh-ruh-vwah)*
—until tomorrow	—à demain
How are you today	Comment allez-vous aujourd'hui *(como-tahlay voo-zoezur-dwee)*

Anatomical

head	-	la tête	neck	-	le cou
eyes	-	les yeux	chest	-	la poitrine
ears	-	les oreilles	heart	-	le coeur
nose	-	le nez	lungs	-	les poumons
mouth	-	la bouche	shoulders	-	les épaules
teeth	-	les dents	back	-	le dos
tongue	-	la langue	arms	-	les bras
throat	-	la gorge	hands	-	les mains
fingers	-	les doigts	bladder	-	la vessie
legs	-	les jambes	rectum	-	le rectum
feet	-	les pieds	buttock	-	les fesses
stomach	-	l'estomac	hips	-	les hanches

General questions

do you feel sick	vous sentez-vous malade
do you have pain	avez-vous des douleurs
is it much pain	est-ce-que cela fait très mal
mild pain	un peu de douleur
where	où
here	ici
when	quand
how many years	combien d'années
how many days	combien de jours
how many hours	combien d'heures
how many times	combien de fois
where were you born	où êtes-vous né
how old are you	quel âge avez-vous

Directions to patients

do as I do	faites comme moi
relax	laissez-vous faire
relax more	détendez-vous plus
open your mouth	ouvrez la bouche
open your eyes	ouvrez les yeux
breathe deeply	respirez profondément
breathe through your mouth	respirez par la bouche
hold your breath	retenez votre haleine

push	poussez
cough	toussez

Diseases

measles	rougeole
scarlet fever	fièvre scarlatine
chicken pox	varicelle
smallpox	variole (la picote)
pneumonia	pneumonie
typhoid fever	fièvre typhoide
enteritis	enterite
U.R.I.	infection de l'arbre respiratoire superieur, *or,* rhume
mumps	oreillons

Systemic inquiry

Head	
trauma	un coup
unconscious	sans connaissance
did you faint	avez-vous perdu connaissance
are you dizzy	avez-vous des vertiges
headache	mal de tête
Eyes	
sight	la vue
clear vision	bonne vue
near	près
far	loin
Ears	
he is deaf	il est sourd
noise in the ears	des bruits dans les oreilles
Nose	
coryza	coryza
did you have a nosebleed	avez-vous saigné du nez
Throat	
do you have frequent sore-throat	avez-vous souvent mal à la gorge

Never needs an ordinary grease job

The "compact" and the "import" on the racks need a complete grease job every other month. The New British TRIUMPH/Herald *never* does. Only 4 parts ever need greasing, and then only once every 6,000-12,000 miles.

This TRIUMPH has so many innovations that engineers call it "3 full years ahead" of any other economy car. **Resident Physician** chose it as the car with the features hospital staff physicians wanted most. Here are two more reasons:

Its wheels turn farther than any other car's (45 degrees each way). Thus it is so maneuverable that you can parallel park with only 18 inches leeway on either end. The body is made in 7 easily replaceable sections. Damage can be repaired more quickly and less expensively.

Unlike most American cars, the TRIUMPH/Herald comes fully equipped with everything but white walls and radio. Yet it still costs less* than the *lowest*-priced "compact." Why not call your TRIUMPH dealer for an eye-opening demonstration. He's in the Yellow Pages. Also see the TRIUMPH TR-3 sports car. It will put you in a *two*-car mood.

TRIUMPH

Sedan—$1849; Sports Coupe—$2149; Convertible—$2229. POE, plus state and/or local taxes. Standard-Triumph Motor Co., Inc., Dept. RH-110, 1745 B'way, N.Y. 19.

Cardio-respiratory

do you tire easily	vous fatiguez-vous facilement
are you short of breath	avez-vous la respiration courte, *or* êtes essoufflé
does your heart beat fast	est-ce que le coeur vous bébat avez-vous des battements de coeur
do your ankles swell	est-ce que vos chevilles enflent
do you have pain in the chest	avez-vous mal à la poitrine, *or* un point de côte
—sharp pain	—une douleur vive
—dull pain	—une douleur sourde
when you breathe	quand vous respirez
do you cough	toussez-vous
do you spit	crachez-vous
sputum	la crachat
bloody sputum	le crachat avec du sang, *or,* du sang dans les crachats
have you lost weight	avez-vous maigri
does someone in your family have a cough	y a-t-il quelqu'un qui tousse dans votre famille

Gastro-intestinal

do you have a good appetite	avez-vous bon appétit
do you have a poor appetite	avez-vous mauvais appétit
are you nauseated	avez-vous des nausées
were you nauseated	avez-vous eu des nausées
do you vomit	vomissez-vous
do you have diarrhea	avez-vous de la diarrhée
are you constipated	êtes-vous constipé
did you have a B.M. today	êtes-vous allé à la selle aujourd'hui les matières fécales (les selles)

Feces

black	noires
white	blanches
yellow	jaunes
brown	brunes

One pharmaceutical research executive points up the importance of failures as guideposts to success in the search for new or improved drugs when he says:

"Failure is our most important product."

The pharmaceutical industry's investment in research has been growing much faster than the industry itself. Last year the prescription drug companies spent a record $197 million for research, a five-fold increase in the space of ten years. Such an investment is possible, of course, only when there are profits. • This growth in privately financed research has sent the volume of laboratory failures soaring. For two years in a row the pharmaceutical industry has tested more than 100,000 substances in the search for new medicines. Fewer than two per cent showed enough promise for clinical testing. Only a handful will ever be sold as prescription drugs. The odds against finding a product with therapeutic value probably exceeded 2000-to-1. • But year by year, as the failures mount, the successes also increase, putting new or improved medications at the disposal of the medical profession. And the public benefits through better health, specific cures, shorter hospitalization, longer lives. • This is only one part of the massive assault on disease that engages the health team headed by the medical profession and embracing hospitals, nurses, pharmacists, technicians, and colleges. It is an effort that could only take place in a society which encourages individual freedom and guarantees incentives to freedom of enterprise.

This message is brought to you in behalf of the producers of prescription drugs. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C.

bloody	sanglantes, (avec du sang)
do you have cramps	avez-vous des crampes
after meals	après les repas
before meals	avant les repas
did you take a laxative	avez-vous pris un laxatif
did you take castor-oil	avez-vous pris de l'huile de ricin (castor)

Genito-urinary

urine	l'urine
do you get up at night to urinate	vous levez-vous la nuit pour uriner
does it burn	est-ce que ca brûle
chills	des frissons
fever	de la fièvre

Obstetrics and Gynecology

at what age did you begin to menstruate	a quel âge avez-vous eu votre premier menstruation, *or,* en vos regles pour la premiere fois
how many days do you flow	l'écoulement dure combien de jours
do you have a discharge	avez-vous des pertes blanches
when was your last menstrual period	quel est la date de votre dernière menstruation (vos regles)
are you pregnant	êtes-vous enceinte
do you have pain with your periods	avez-vous des regles douleureux
how many times have you been pregnant	combien de fois avez-vous été enceinte
how many children have you had	combien d'enfants avez-vous eus
how much did the largest weigh at birth	quel était le poids du plus gros
what was the duration of labor	votre travail a duré combien de temps

Extremities

do you have pain in the joints	avez-vous des douleurs dans les articulations (jointures)

Pediatrics

was there any trouble with the delivery	avez-vous eu des difficultés á l'accouchement
how are the child's stools	comment sont les selles de l'enfant
constipated	constipées
diarrhea	diarrhées
how many in one day	combien (de selles) par jour
does the child eat well	l'enfant mange-t-il bien
any vomiting	est-ce qu-il vomit
does the child turn blue	l'enfant devient-il bleu
does the child seem tired	l'enfant semble t-il fatigué
does it hurt	est-ce que cela fait mal
it won't hurt	cel ne fera pas mal
it will be over in a minute	cela sera fini dans une minute
do you want a piece of candy	voulez-vous un morceau de bonbon
did you take the temperature	avez-vous pris sa température
what was the temperature	quelle était sa température
what a big handsome boy	quel beau gros garcon
what a beautiful girl	oh, la jolie petite jeune fille
baby	bébé
good	bien

QUIET, PLEASE!

YOUR WIFE'S TALKING

WIVES' CLUB

Joanne Leff

"Conversation, companionship and coffee" sum up the primary purpose of the Intern-Resident Wives' Club of Los Angeles County General Hospital.

Wives of interns and residents are in a unique and temporary situation. Many are from out of town or out of state; as "displaced persons," their needs are obvious. However, even those born and raised in Los Angeles and thoroughly familiar with the city, have much to gain from Wives' Club.

Naturally, I have many friends with no connection with Medicine. "I don't see how you stand it, Jo," a slim brunette whose husband works for the Board of Education will sigh after describing their month's vacation in the High Sierras. She and I have a great deal in common, but I cannot discuss my situation too often without her feeling guilty and my feeling resentful.

Schedule

"I haven't seen Gordon for three days," our red-headed vice president moans over coffee after a meeting. Somehow this is cheering to the petite, newly-married intern's wife

from Ohio whose husband's schedule of twenty-four on and twenty-four off is overwhelming. "Wait until he starts GYN," a resident's wife will laugh, "you'll wonder what you were complaining about."

However, we try to offer more than a monthly crying towel. Our speakers' subject will vary from flower arranging to literature.

Our philanthropies, because of our economic situation and the amount of time each member has to spare are, by necessity, simple. We like to do things for the hospital. Last year groups of girls went each Monday night to help entertain the T. and A.'s prior to surgery. We are now knitting slipper socks for the Peds. unit.

Our most successful philanthropic event was taking some pediatric patients to the circus. Twenty patients were selected and traveled to the circus in a bus arranged for by the hospital. A doctor from the hospital also came, and the hospital kitchen packed the lunches. This was a necessity since many of the children were on special diets. It was also necessary to make sure that the diabetics did not eat cotton candy and those children on a salt-free diet did not eat salted peanuts. One of the local men's clubs paid for the tickets. Needless to say, the children had a wonderful time, but of course, so did everyone.

Four years

Our Wives' Club was started approximately four years ago by four girls whose husbands had attended the University of Southern California School of Medicine. They had been active in the wives' club there and had felt the lack of such a group at County. The first meeting, held at the home of one of these girls, was attended by only four women due in part to the fact that a complete mailing list was not yet available. However, the second meeting was so successful that there was not enough room in the house for everyone, so the meeting place was changed to the hospital where it has remained ever since. During the second year the group became more formal with officers, dues, and at last a complete mailing list.

Our group discovered through RESIDENT PHYSICIAN that Massachusetts General Hospital had a wives' club. We corresponded with them to get information on

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The author is president of the Intern-Resident Wives' Club, Los Angeles County General Hospital.

organizing and suggested hearing more from them through RESIDENT PHYSICIAN. They were also interested in contacting other wives' clubs. These girls were fortunate in that they were greatly aided by the attending staff wives' auxiliary. Los Angeles County General Hospital has no such group and this lack has been one of our biggest problems. The Massachusetts General Hospital Wives' Club sent us a copy of their constitution and newsletter. We adapted their constitution to fit our needs and sent it to them with a copy of our newsletter.

Social

For our first social affairs we collaborated with the Intern-Resident Association. Our spring picnic bears mentioning. It was held at a doctor's home with lovely grounds and an inviting swimming pool. The picnic began at noon and ended about ten p.m. The extended run was necessary so that those on duty might stop by for a few hours. The attending staff was invited too, and after enjoying themselves they returned to the hospital to relieve some of the interns or residents so that they in turn might go to the picnic. The men's group barbecued the steaks. The girls contacted the hospital kitchen and they cooperated by supplying salads and bread (since we reasoned we were saving them one meal per intern or resident that day). Both Wives' Club and the Intern-Resident Association helped in making posters and sending out notices.

Getting started

For hospitals without an organization such as ours, the intern or resident wives who would like to start one might derive benefit from our experiences. The following people can greatly help: The Medical Director, the Director of Volunteer Services, the Occupational Therapy Department, the Intern and Resident Training Office, the Attending Staff Association and their Auxiliary.

However, the success of the organization will depend mainly on those who wish to form it.

The incoming interns must be contacted before they arrive. The new wives must know of the advantages of such an organization and must be instilled with a desire to belong. Most important, the hospital must know that the group is there and the group must feel that they are part of the hospital.

July

Our new year begins July first when the hospital year does. At the July meeting we have no speaker. Los Angeles is an enormous city and our members are scattered. So after a brief business meeting the girls are separated into small groups according to the area in which they live. They all have so much in common that there is no reserve and after a few minutes each group is chattering happily.

While things are kept simple they are always well done. Flowers adorn the table at the Student Nurses' Residence Hall where we meet every first Wednesday. Coffee is served in an attractive carafe. At our first meeting the group from Monterey Park was talking with such enthusiasm (they had just discovered they all lived on the same street!) we hated to interrupt them for coffee and cake. Someone from Canoga Park which is a little further from County and therefore not so heavily populated with County personnel, was happy to learn there was another resident's family living just a few miles away.

Our vice president appoints a chairman in each of the different areas. The chairman and the girls living in these areas then get together informally between meetings at any time convenient to them for "conversation, companionship and coffee."

[*Mrs. Leff tells us she would welcome letters from other wives interested in forming clubs. Also, if your husbands are interested in a first-class "House Staff Manual," have them drop a line to the Intern-Resident Association, Los Angeles County General Hospital, Los Angeles, California.—Ed.*]

What's the Doctor's Name?

He was born in 1738, the son of a lawyer at Saintes, France. In 1763, he matriculated as a medical student in Paris and five years later was graduated in Rheims.

He received his official degree in medicine in Paris in 1770. Later, he was appointed a *docteur-regent* of the medical faculty — the highest distinction possible — and became a popular teacher and practitioner.

In 1784, he was chosen a member of the commission for the investigation of Mesmer's theory concerning animal magnetism. This commission, appointed by Louis XVI, included, among others, Lavoisier and Benjamin Franklin. The commission branded Mesmer's work "useless."

In 1788, he published a pamphlet considered to be one of the political manifestos that helped to pave the way for the Revolution. It presented the claims of the commons for at least as many representatives in

e States-General as were accorded the nobility and the ergy. As a result he was elected people's representative for the ity of Paris and became the resident of the Assembly.

At that time he proposed that xecution by decapitation should o longer be confined to the upper class and that it was desirble to render the process of exeution as swift and painless as ossible. He suggested a machine imilar to those used in many ountries a century before. The achine was constructed by a erman mechanic and erected on the Place de Greve in 1792.

After having carried several names the machine was eventually given the name of the doctor who first suggested its use. He could not have foreseen that this mechanism would become the tool of destruction in a Reign of Terror.

After the Terror he founded the Academie de Medecine. He was an ardent follower of Jenner and headed a French committee for the propagation of vaccination. He died in 1814. Can you identify this doctor? *Answer on page 168.*

SEE Page 138

VIEWBOX DIAGNOSIS

(from page 23)

ANEURYSM OF THE POSTERIOR COMMUNICATING ARTERY

Note dye outlining the aneurysm at the origin of the posterior communicating artery.

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WHAT'S THE DOCTOR'S NAME

(Answer from page 166)

Joseph Ignace Guillotin

•

RESIDENT RELAXER

(puzzle on page 27)